

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 0 6 6

FOR  
STATE  
REGISTRAR

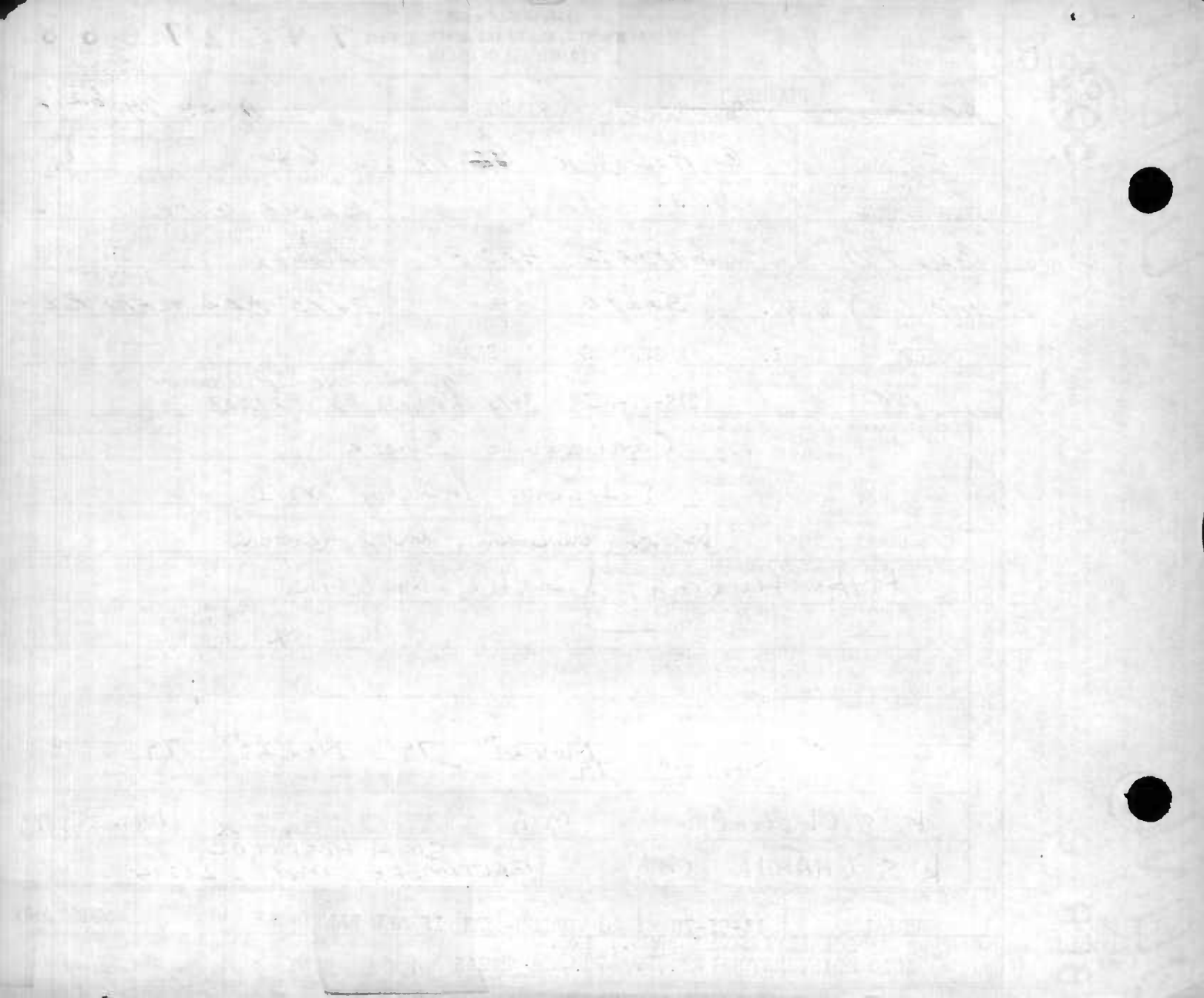
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FLORENCE ABRAMSON			2a. DATE OF DEATH MONTH DAY YEAR 11 23 79			2b. HOUR 6:27 P.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 10 16 17	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.				
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP		12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS DURING LIFE) CREDIT CLERK		12b. KIND OF BUSINESS OR INDUSTRY HOSCHILD KOHN		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH I. ROSENBERG			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH STEIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-09-8254		17. INFORMANT MR. MAURICE ABRAMSON 3415 REDMAN RD. #21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Shock 410 - DUE TO, OR AS A CONSEQUENCE OF (b) Extensive Inferior M.I. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis, Hypertension							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension, Diabetes mellitus.							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov 20 <sup>th</sup> 1979 to Nov 23 <sup>rd</sup> 1979, that (I) (we) last saw the deceased alive on Nov 23 <sup>rd</sup> 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE K. S. CHAMAL		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Nov 23 <sup>rd</sup> 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. S. CHAMAL MD.		22e. ADDRESS SINAI HOSPITAL BALTIMORE, MD, 21215.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-25-79		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR NOV 28 1979		25b. REGISTRAR'S SIGNATURE P. J. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Roy</b> <b>W.</b> <b>Acors</b>		2a. DATE OF DEATH MONTH <b>11</b> DAY <b>25</b> YEAR <b>79</b>		2b. HOUR <b>3:22</b> AM	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>12</b> YEAR <b>1925</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Millwright</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Edgemere</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE LAST <b>Acors</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Doshie</b> MIDDLE LAST <b>Dillard</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>212-20-6819</b>		17. INFORMANT <b>2113 Sparrows Point Road</b> <b>Gertrude K. Acors</b> <b>Balto. MD 21219</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>1 hr</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES MELLITUS</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Bradley S. Benavise</b> MD				22c. DATE SIGNED <b>11/25/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRADLEY S. BENAUISE</b>				22e. ADDRESS <b>BALTIMORE CITY HOSPITALS</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/28/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barney K. Benavise</b>	
26. ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>					

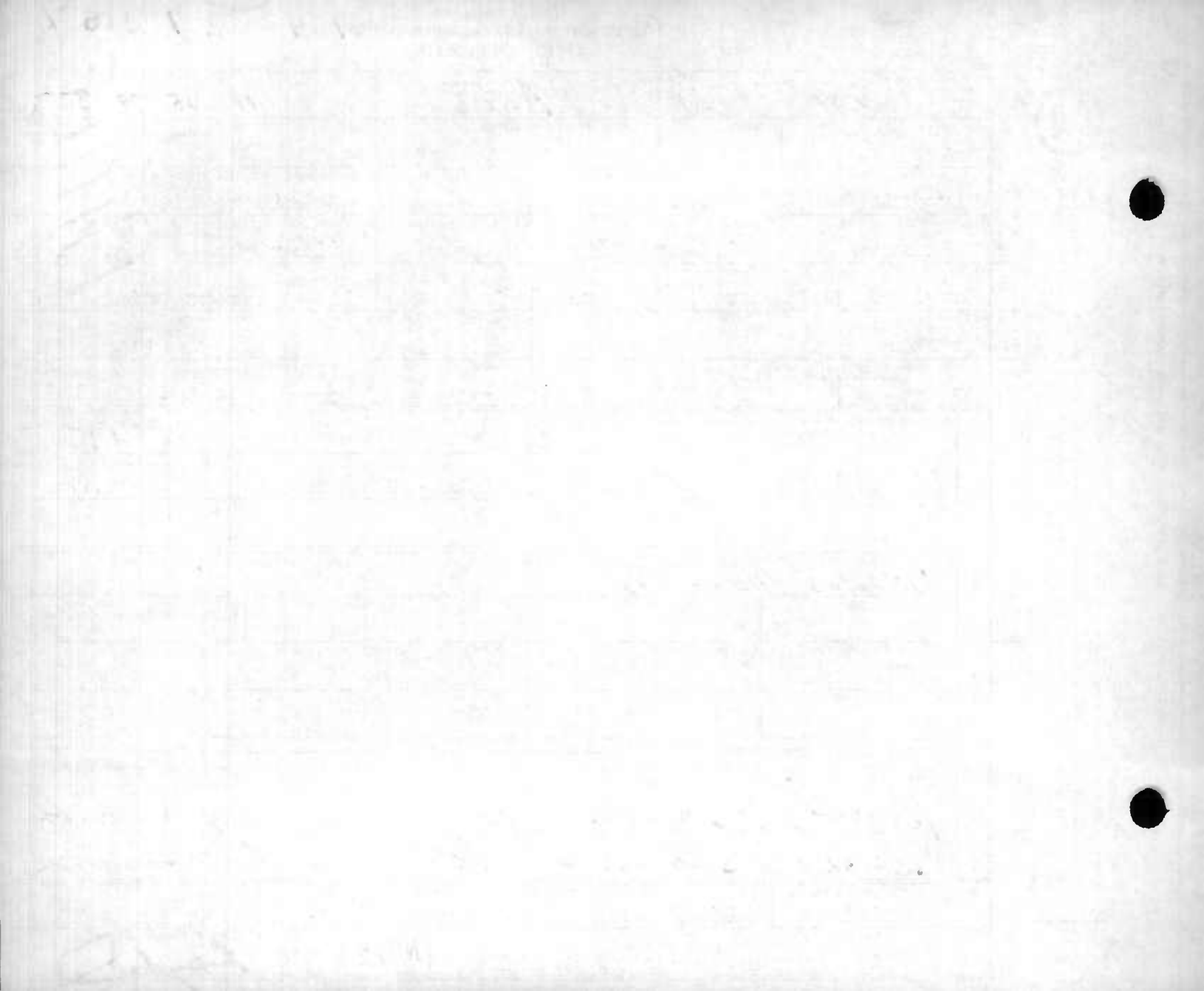
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

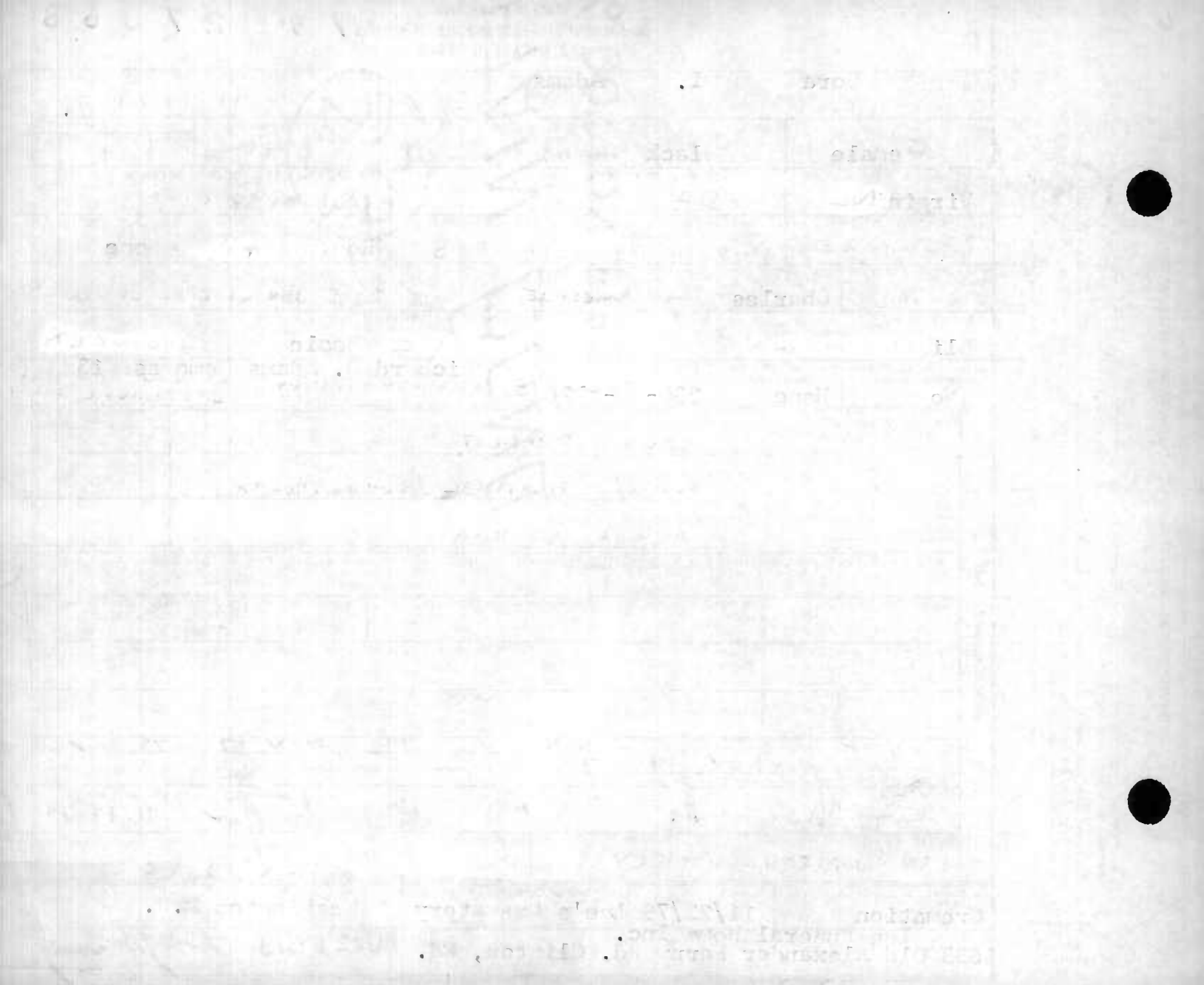
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 7 0 6 8	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		1. DECEASED NAME Cora Adams		2a. DATE OF DEATH MONTH DAY YEAR	
CORA		ADAMS		11 17 79	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		Black		MONTH DAY YEAR	
				06 30 38	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Virginia		USA		41	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTIMORE		UNIV. OF MD. HOSP IPHB		BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Housewife		None			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD		Charles		MECHANICSVILLE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Elisha Stanfield		Susie Beale			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMATION	
No		None		230-50-5726	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		CALDIAL ARREST	
4939		DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		POSSIBLE BILATERAL PNEUMOTHORAX	
		DUE TO, OR AS A CONSEQUENCE OF			
		(c)		ACUTE ASTHMA	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from NOV 10 19 79, to NOV 17 19 79, that (we) lost saw the deceased die on NOV 17 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Egna Quaison-Sackey		MD		11. 17. 79.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
EGNA QUASON-SACKEY		UNIV. OF MD. HOSP BALTIMORE 21202			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		11/22/79		Lee's Crematory	
24. FUNERAL DIRECTOR'S NAME		24. FUNERAL DIRECTOR'S ADDRESS		25a. DATE RECEIVED BY REGISTRAR	
6633 Old Alexander Ferry Rd.		Lee's Crematory		NOV 26 1979	
25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE			
J. H. McCreedy		J. H. McCreedy			

BP.



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					7 9 2 7 0 6 9					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
Irene Adams					11-25-79 6 A. M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Female		Black		MONTH 6 DAY 3 YEAR 00		79 YRS.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA				Baltimore MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		Lafayette Square Nw. Ctr.				Unknown				
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland							Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
John Adams					Josephine Adams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					215-58-0894		Mrs. Carrie Wright Baltimore, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Diabetic Mellitus										
2500 DUE TO, OR AS A CONSEQUENCE OF (b)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)										
Atherosclerotic Heart Disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3-13 1975 to 11-25 1979, that (I) (we) lost saw the deceased alive on 11-25 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
Reginald D. Crosley								11-26-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
Reginald D. Crosley, M.D.					1235 E. Monument Street Balto Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		11/27/79		Piney Grove		Boring, Md.				
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Eline Funeral Home Reisterstown, Md. 21136					NOV 29 1979		[Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

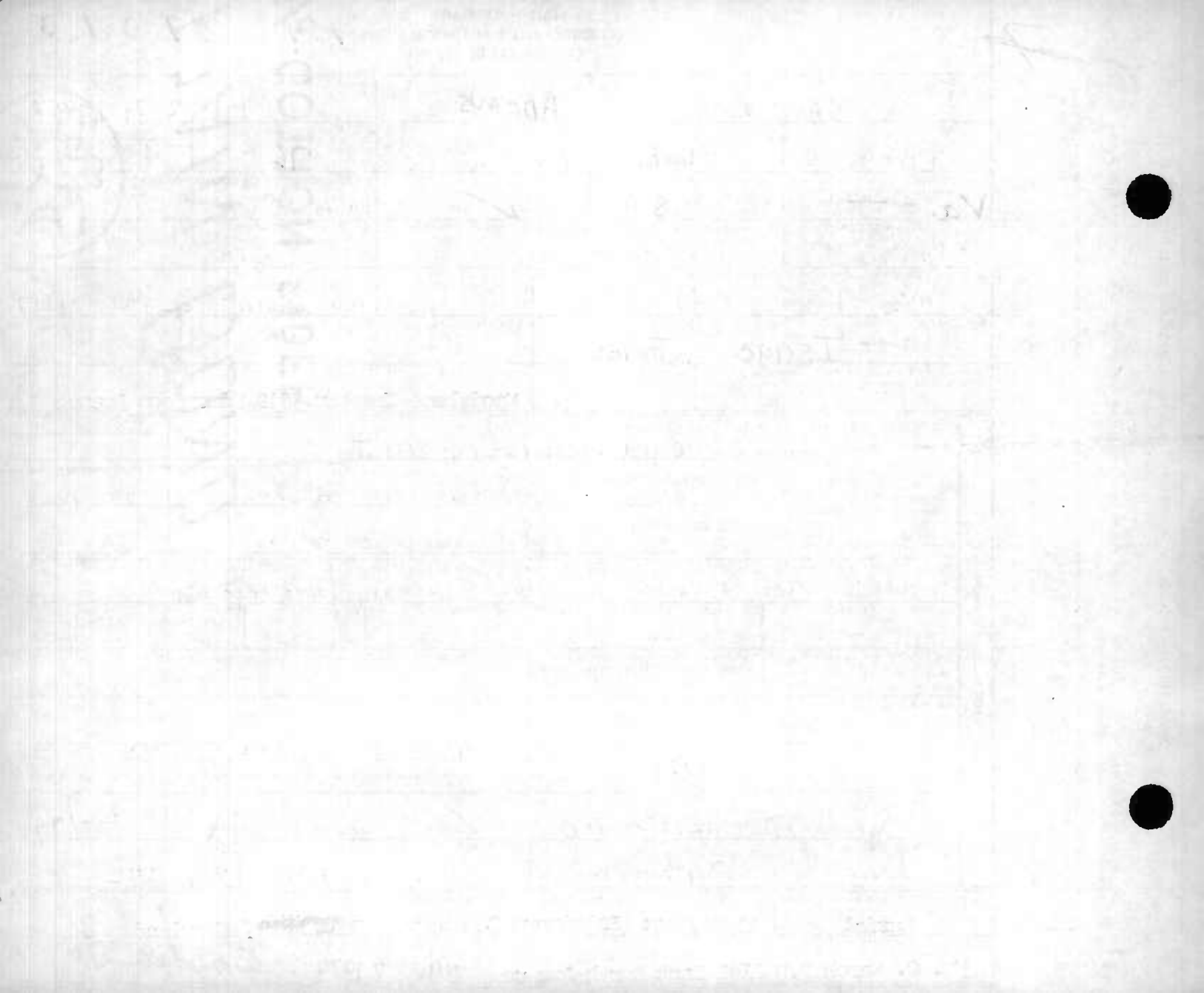
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH
NANNIE				ADAMS	MONTH DAY YEAR
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)
FEMALE		Black	MONTH DAY YEAR		76 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
Va. U.S.A.		U.S.A.			BALTO. CITY MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTO		UNIV OF MD.		N/A	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD		BALTO CITY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1102 DRUID HILL AVE. 21217
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)			
MA Isaac		JONES		N/A	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
N/A				Magdalene Chester 2649 Edmondson Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio respiratory arrest</u> <u>2500</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probable myocardial infarction or</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pulmonary embolus</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>adult onset diabetes mellitus, urinary tract infection</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21/77</u> , 19 <u>77</u> , to <u>11/22</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>11/22/77</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
John M. Bathon MD				11/22/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
John M. Bathon M.D.		UNIV OF MD HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		11/28/1979	Baltimore Cemetery	Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H		1101 East North Avenue		NOV 27 1979 [Signature]	

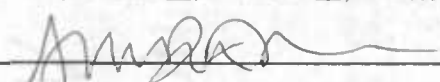
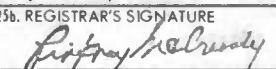
MEDICAL CERTIFICATION

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1702 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27071			
1. DECEASED NAME (TYPE OR PRINT) <b>TERRY S. ADAMS</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 11 25 1979		2b. HOUR <b>M</b>	
3. SEX <b>male</b>		4. RACE <b>negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 3 48</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>31</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>11 25 1979</b>		2d. HOUR <b>9a</b> <b>M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> <b>MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS <b>1525 Wolfe Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vernon Robinson</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Geraldine Adams</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Geraldine Hill</b>				ADDRESS <b>1525 Wolfe Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Long-term complications of gunshot wound of chest</b> <b>969-</b> DUE TO, OR AS A CONSEQUENCE OF (unspecified weapon) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 5-23- 1976</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject shot.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Maizel &amp; Norfolk Ave., Balto. Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>11-26-79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/30/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				ADDRESS <b>1101 East North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		25b. REGISTRAR'S SIGNATURE 			

THE UNIVERSITY OF CHICAGO  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
<div style="display: flex; justify-content: space-between;"> <div> <p>FOR 1 - STATE REGISTRAR</p> </div> <div> <p>7 9 2 7 0 7 2</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>1. DECEASED NAME (TYPE OR PRINT)</p> <p>FIRST: William J. LAST: Adams</p> </div> <div> <p>2a. DATE OF DEATH</p> <p>MONTH: 11 DAY: 17 YEAR: '99</p> </div> <div> <p>2b. HOUR</p> <p>8:45 M</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>3. SEX</p> <p>Male</p> </div> <div> <p>4. RACE</p> <p>White</p> </div> <div> <p>5. DATE OF BIRTH</p> <p>MONTH: 02 DAY: 26 YEAR: 06</p> </div> <div> <p>6. AGE (IN YEARS LAST BIRTHDAY)</p> <p>73 YRS.</p> </div> <div> <p>IF UNDER 1 YEAR</p> <p>MONTHS: DAYS: HOURS: MIN:</p> </div> <div> <p>IF UNDER 24 HRS</p> <p>HOURS: MIN:</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)</p> <p>MD</p> </div> <div> <p>7b. CITIZEN OF WHAT COUNTRY?</p> <p>U.S.A.</p> </div> <div> <p>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> </div> <div> <p>9. BALTIMORE CITY OR COUNTY OF DEATH</p> <p>Baltimore MD.</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>10. CITY OR TOWN OF DEATH</p> <p>Baltimore</p> </div> <div> <p>11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</p> <p>South Baltimore General Hospital</p> </div> <div> <p>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)</p> <p>Machineist</p> </div> <div> <p>12b. KIND OF BUSINESS OR INDUSTRY</p> <p>Machine Part Co</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)</p> <p>13a. STATE: MD 13b. COUNTY: 13c. CITY OR TOWN: Baltimore</p> </div> <div> <p>13d. INSIDE CITY LIMITS?</p> <p>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> </div> <div> <p>13e. STREET ADDRESS</p> <p>2409 Arbuton Ave. Balto MD. 21230</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>14. FATHER'S NAME</p> <p>FIRST: William J. LAST: Adams SR.</p> </div> <div> <p>15. MOTHER'S MAIDEN NAME</p> <p>FIRST: Florence MIDDLE: Louise LAST: Deckert.</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)</p> <p>NO</p> </div> <div> <p>16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)</p> <p>215-10-689A</p> </div> <div> <p>17. INFORMANT</p> <p>Herbert Adams SR. 8438 Bay Drive 21122</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>18. CAUSE OF DEATH (Enter only one cause per item 18. (a), (b), and (c). PART I. DEATH WAS CAUSED BY</p> <p>IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b></p> <p>1579</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) <b>probably Pancreas</b></p> <p>(c)</p> </div> <div> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)</p>									
<div style="display: flex; justify-content: space-between;"> <div> <p>19a. DATE OF OPERATION</p> </div> <div> <p>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> </div> <div> <p>20a. AUTOPSY?</p> <p>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> </div> <div> <p>20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?</p> <p>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> </div> <div> <p>21b. TIME OF INJURY</p> <p>HOUR A.M. MONTH DAY YEAR</p> <p>P.M. 19</p> </div> <div> <p>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>21d. INJURY OCCURRED</p> <p>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> </div> <div> <p>21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</p> </div> <div> <p>21f. LOCATION</p> <p>STREET CITY OR TOWN COUNTY STATE</p> </div> </div>									
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>10-08</u> 19 <u>99</u>, to <u>11-17</u> 19 <u>99</u>, that (I) (we) last saw the deceased alive on <u>11-17</u> 19 <u>99</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
<div style="display: flex; justify-content: space-between;"> <div> <p>22b. SIGNATURE</p> <p>Myeung Gin Lim</p> </div> <div> <p>DEGREE</p> <p>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/></p> </div> <div> <p>22c. DATE SIGNED</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>22d. PHYSICIAN'S NAME (TYPE OR PRINT)</p> <p>Myeung Gin Lim</p> </div> <div> <p>22e. ADDRESS</p> <p>South Baltimore General Hospital</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>23a. BURIAL, CREMATION, REMOVAL (SPECIFY)</p> <p>Buried</p> </div> <div> <p>23b. DATE</p> <p>11-20-79</p> </div> <div> <p>23c. NAME OF CEMETERY OR CREMATORY</p> <p>Landon Park Cem.</p> </div> <div> <p>23d. LOCATION</p> <p>CITY OR TOWN: Baltimore COUNTY: STATE: Md.</p> </div> </div>									
<div style="display: flex; justify-content: space-between;"> <div> <p>24. FUNERAL DIRECTOR</p> <p>NAME: John J. Comer &amp; Son Inc. 901 Hollins St. 21223 ADDRESS:</p> </div> <div> <p>25a. DATE REC'D. BY REGISTRAR</p> <p>NOV 20 1979</p> </div> <div> <p>25b. REGISTRAR'S SIGNATURE</p> <p>Henry McBrady</p> </div> </div>									







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

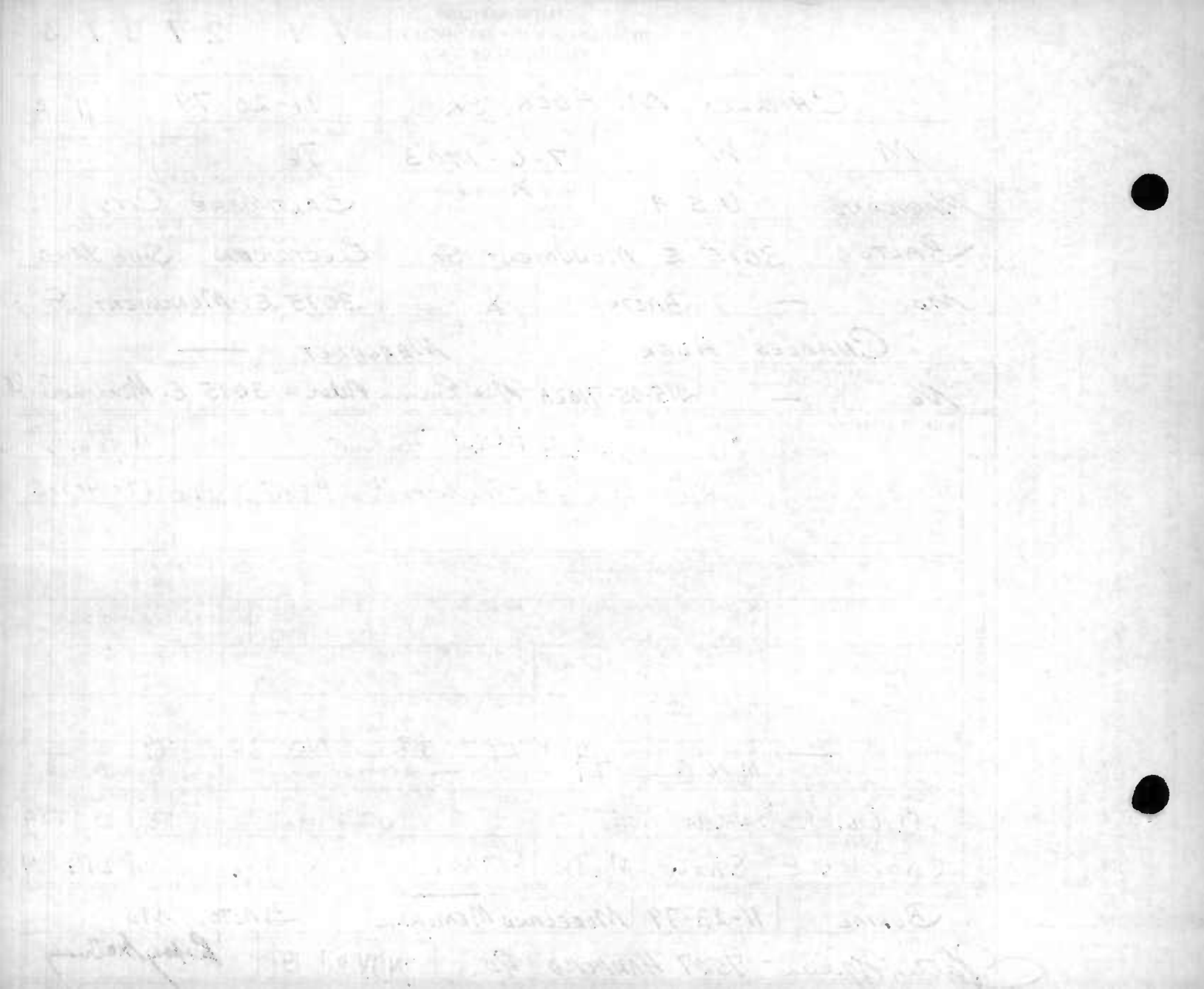
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9 2 7 0 7 3 CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES M. ADER, SR.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-20-79</b>			2b. HOUR <b>11 A.M.</b>		
3 SEX <b>M</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-6-1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3015 E. MONUMENT ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ELECTRICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SHIP YARD.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE <b>MD.</b>		13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>BALTO.</b>		13e. STREET ADDRESS <b>3015 E. MONUMENT ST.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES ADER</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET —</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>215-05-7102A</b>		17 INFORMANT ADDRESS <b>Mrs. Emma Ader - 3015 E. Monument St.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <b>3989 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b): <b>Rheumatic &amp; Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>17+ years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (the hospital) attended the deceased from <b>Oct 17</b> , 19 <b>62</b> , to <b>Nov 20</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov 9</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Charles E. Shaw M.D.</b>					DEGREE			22c. DATE SIGNED <b>Nov 21, 1979</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles E. Shaw, M.D.</b>					22e. ADDRESS <b>607 W. Joppa Rd, Towson, Md 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>					23b. DATE <b>11-23-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Harry Miller</b>					ADDRESS <b>7527 HARFORD RD.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1979</b>		
								25b. REGISTRAR'S SIGNATURE <b>Harry Miller</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9		2 7 0 7 4											
FOR 1. STATE REGISTRAR				CERTIFICATE OF DEATH																			
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
DAVID				L.				AGER		11		20		79		11		55 AM					
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR				8. IF UNDER 24 HRS.			
Male				White				July 30, 1938				41				YRS				MONTHS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland				USA								BALTIMORE CITY				MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
BALTIMORE				UNION MEMORIAL HOSPITAL				Accountant				St. of Md.											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				1101 N. Calvert St.							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
Joseph				M. Ager				Valette				Schmidt											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
No				219 32 7502				Mr. Joseph Ager				Balto., Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) RESPIRATORY ARREST																							
3440 DUE TO, OR AS A CONSEQUENCE OF																		2 wks					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <del>CHLORIDIA</del> PSYCHOTIC DEPRESSION / CATATONIA																							
DUE TO, OR AS A CONSEQUENCE OF (c) CHLORIDIA																		25 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
				HOUR A.M. MONTH DAY YEAR																			
				P.M. 19																			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION															
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET				CITY OR TOWN COUNTY STATE											
22a. I certify that (he (this hospital) attended the deceased from 11/16, 1979, to 11/20, 1979, that (I) (we) lost saw the deceased alive on 11/20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.																							
22b. SIGNATURE																		DEGREE		22c. DATE SIGNED			
Serauld Ward																		MD		11/20/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																		22e. ADDRESS					
SERALD WARD, M.D.																		UNION MEMORIAL HOSP.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
Burial				11/23/79				Holy Redeemer				Baltimore, Md.											
24. FUNERAL DIRECTOR NAME																		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co.																		NOV 21 1979		[Signature]			
4905 York Road Balto., Md. 21212																							

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

1942

1942

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

1942

1942

Items #5&amp;6 per phone call w/Fun.

STATE OF MARYLAND

FOR  
1 - STATE Home 11/29/79 rc  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 0 7 5

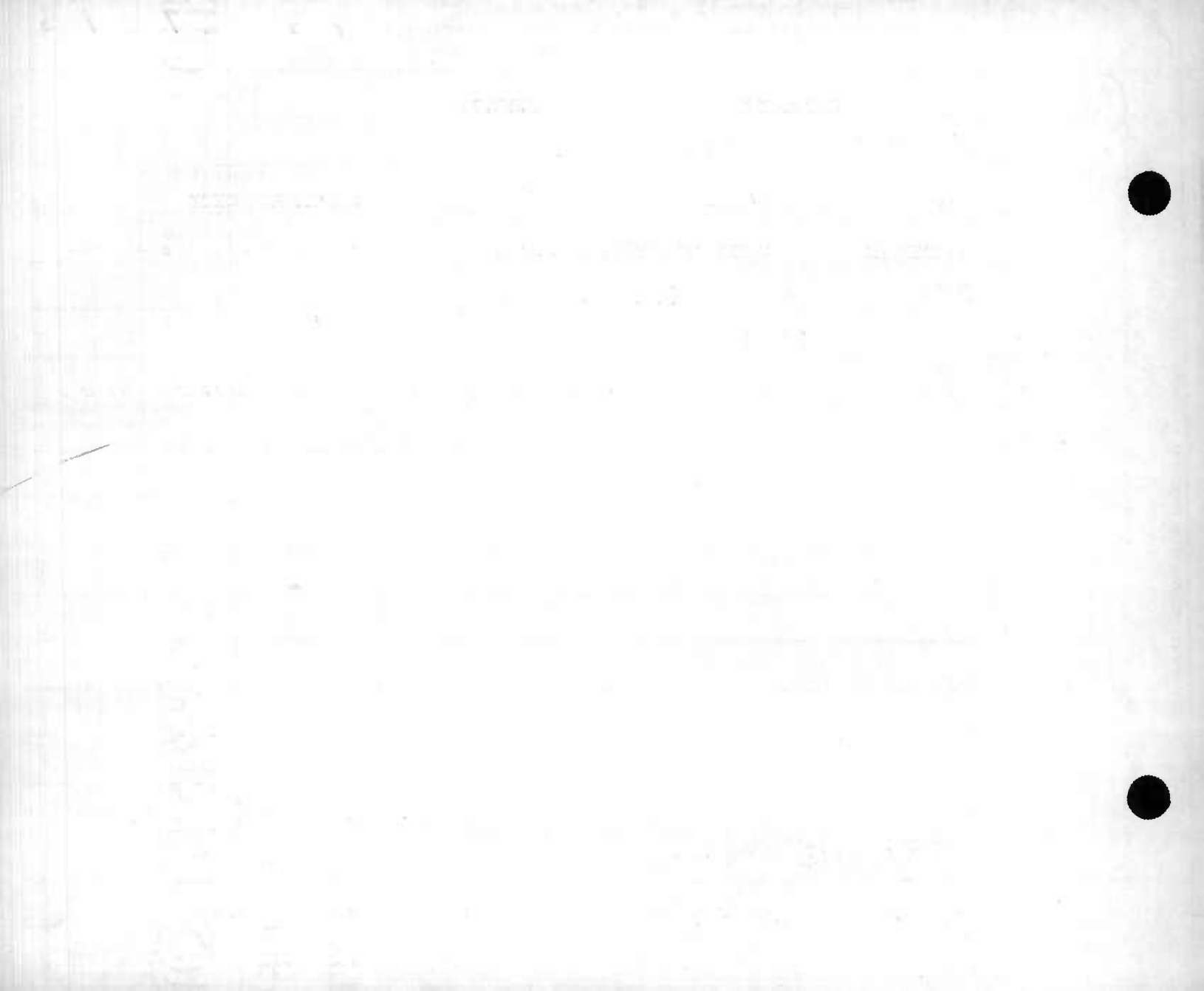
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>KATHERINE</b>			FIRST MIDDLE LAST <b>ALBERGO</b>			2a DATE OF DEATH MONTH DAY YEAR <b>11-20-79</b>			2b HOUR <b>3<sup>55</sup></b> a.m.		
3 SEX <b>FEMALE</b>			4 RACE <b>CAUC.</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 10, 1910</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>			7c. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>SEWING</b>											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>---</b>			13c. CITY OR TOWN <b>BALTO.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>---</b>											
14 FATHER'S NAME FIRST MIDDLE LAST <b>---</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>---</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-01-8140</b>			17 INFORMANT ADDRESS <b>RALBERGO 2927 MILLS AVE.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION and/or SEPSIS</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2500 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DIABETES MELLITUS</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CHRONIC URINARY TRACT INFECTIONS</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>---</b> P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>19/Nov</b> 19 <b>79</b> to <b>20/Nov</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>20/Nov</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sew the body after death.											
22b. SIGNATURE <b>Serall Ward</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>20-NOV-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SERALL WARD</b>			22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11/23/79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>		
24 FUNERAL DIRECTOR NAME <b>Charles E. Clements</b>						ADDRESS <b>3617 Chestnut Ave</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey McCreedy</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and attach them to the certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 0 7 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARJORIE NICHOLS ALBERS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 18, 1979</b>			
3. SEX <b>FEMALE</b>				2b. HOUR <b>6:50 AM</b>			
4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APR 22 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>ANNE ARUNDEL</b> 13c. CITY OR TOWN <b>ANNE ARUNDEL</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>SHERMAN D NICHOLS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AGNES G CARR</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>DR. EDWIN W. ALBERS</b>			
17. INFORMANT ADDRESS <b>DR. EDWIN W. ALBERS</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic oat cell carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 years</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/18 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/18</b> , 19 <b>79</b> , to <b>11/18</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE <b>Jerome E. Granoto MD</b> DEGREE				22c. DATE SIGNED <b>11/18/79</b>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
27a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEROME E. GRANOTO MD</b>				27b. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/23/76</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NOT HOLY REDEEMER CEM. SCHENECTADY NY.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>JOHN M. TAYLOR SONS ANNAPOLIS MD</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP



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MANUAL DATE 11-11-53  
NOVEMBER 18, 1953  
02:30

BALTIMORE CITY

THE BALTIMORE HOSPITAL

4-2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Michael		MIDDLE Albert		LAST Albert		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11 11, 1979		2b. HOUR M 9:05 A.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 14 1908		6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 11 13, 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8 N. Howard Street, Room 220				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8 N. Howard St.			
14. FATHER'S NAME FIRST MIDDLE LAST John Albertowsky				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Psybylska							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II 176-03-6973A		17. INFORMANT ADDRESS 401 Franklin St Kisco Funeral Home Bloomfield N.J.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Carcinoma of prostate with metastasis											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) Assistant				DATE SIGNED 11/13/79			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/16/79		23c. NAME OF CEMETERY OR CREMATORY Rose Mount Park Cem		23d. LOCATION CITY OR TOWN Newark		COUNTY Essex		STATE N.J.	
24. FUNERAL DIRECTOR NAME B. Dabrowski & Son 2818 E. Baltimore St.						25a. DATE REC'D. BY REGISTRAR NOV 19 1979		25b. REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST.,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME(5))  
30M 7/73

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 0 7 8

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BARBARA W. ALEVATO		2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 9, 1979		2b. HOUR 6:00A <sub>M</sub>	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 7 7 1906		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corporation		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Guarscia		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Aquinta		13e. STREET ADDRESS 6523 Colgate Avenue	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 235-30-0901		17 INFORMANT ADDRESS: 6913 Delvale Pl. Joseph A. Alevato Balto. MD 21222	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 496- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION (c) DUE TO, OR AS A CONSEQUENCE OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 10-29-1979 to 11-9-1979, that (I) (we) last saw the deceased alive on 11-9-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE K. Surendra Shenoy		DEGREE		22c DATE SIGNED 11-9-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) K. SURENDRA SHENOY, M.D.		22e ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD 21231		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11/12/79		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
24 FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		ADDRESS 7922 Wise Avenue, Dundalk, MD 21222		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
25a DATE REC'D. BY REGISTRAR NOV 13 1979		25b REGISTRAR'S SIGNATURE [Signature]			



Handwritten signature and date: 10/11/11



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

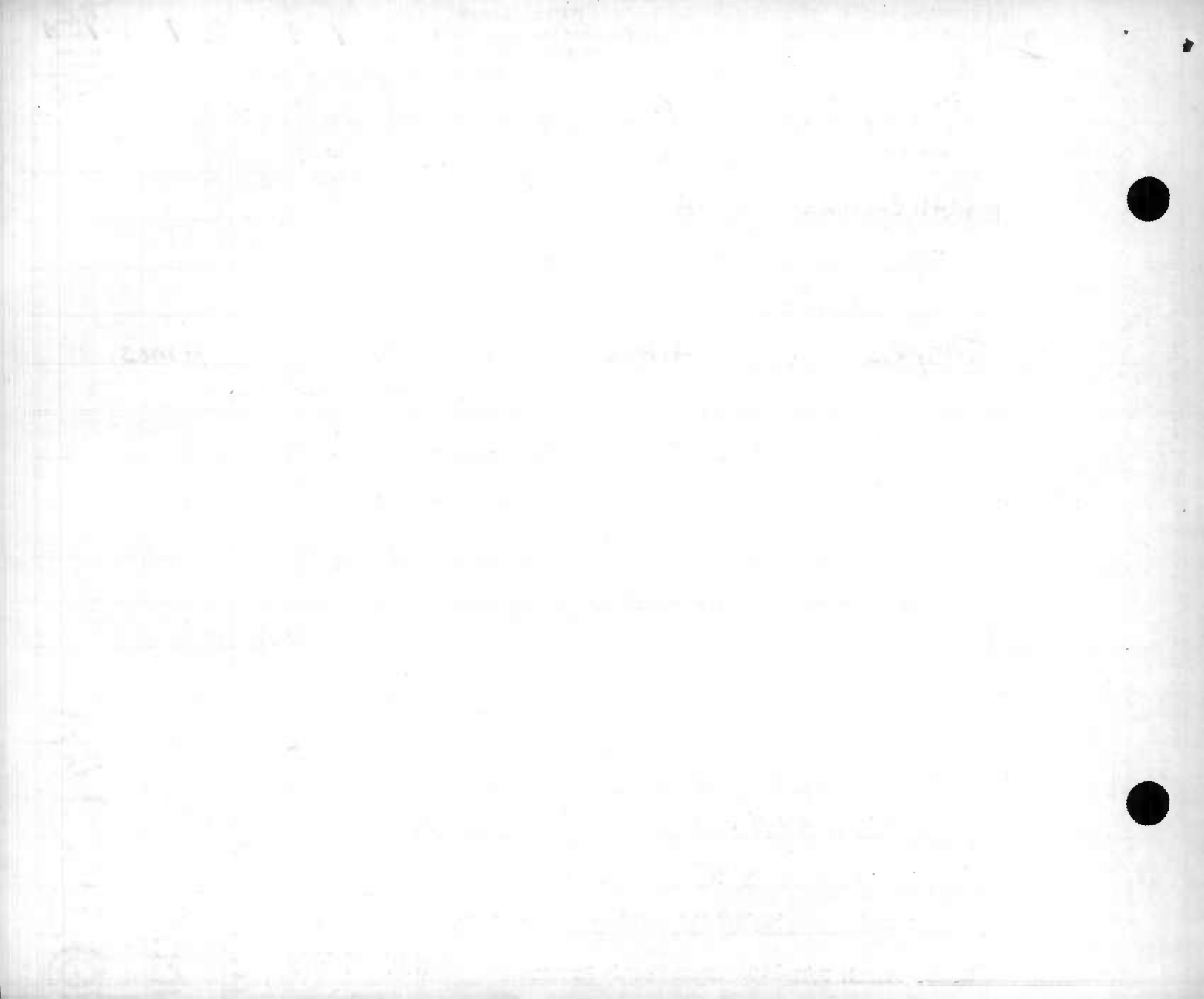
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

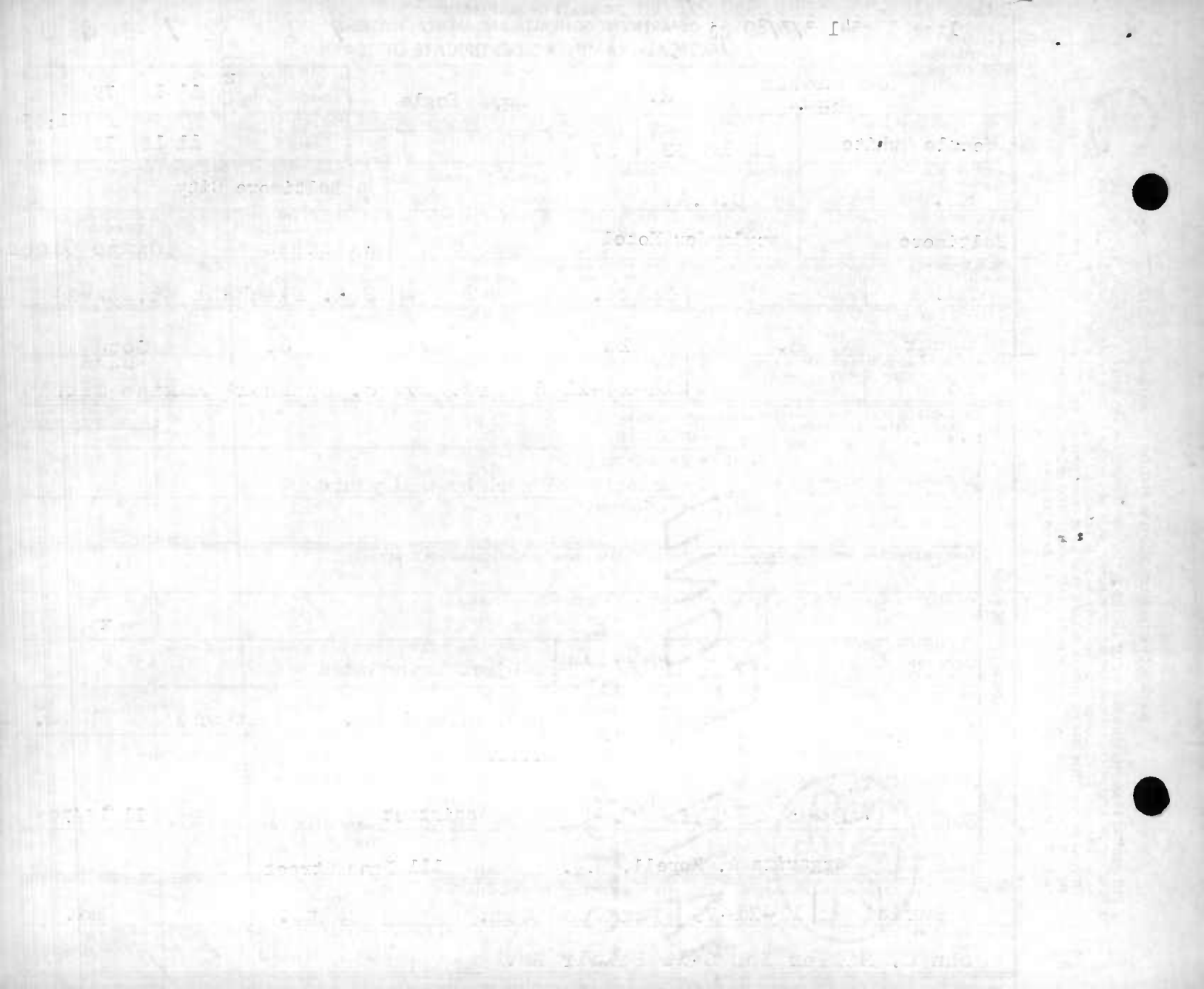
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Allen, Mary F.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 4 1979</b>			2b. HOUR <b>11:20 AM</b>					
3 SEX <b>FEMALE</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 25 32</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balt.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>		13b. COUNTY <b>BALT</b>		13c. CITY OR TOWN <b>BALT.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jasper Allen</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Allen, Rose Amas</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT <b>Rose Gross</b>				ADDRESS <b>1058 Argyle Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST 2° CAROTID</b> <b>1991</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>INVASION by sq. cell Ca.</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/19/79</b> , 19____, to <b>11/4/79</b> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>George Linhardt</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>11/4/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Linhardt MD</b>			22e. ADDRESS <b>Univ. Hospital</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/9/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>			ADDRESS <b>1101 East North Avenue</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27080	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Jeannette		MIDDLE R.		LAST Alm Engle		2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 16 42		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 18 79		11:05 P.M.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Marylander Hotel				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Dixie Diner			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8 E. Pleasant St. 21202			
14. FATHER'S NAME FIRST MIDDLE LAST Oscar H. Alm				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva J. Good							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 214-14-1240		17. INFORMANT ADDRESS Mrs. Eva J. Butzner Maxine Circle 8223					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9838 IMMEDIATE CAUSE (a): Asphyxia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b): Compression of neck by a ligature DUE TO, OR AS A CONSEQUENCE OF (c):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11/18/79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject asphyxiated					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hotel		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6401 Pulaski Hwy. Baltimore Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 11/19/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-21-79		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc 6415 Belair Rd.						25a. DATE REC'D. BY REGISTRAR NOV 23 1979		25b. REGISTRAR'S SIGNATURE H. J. McCreedy			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 0 8 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CARRIE I. ALTFELD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 23 79</b>			2b. HOUR <b>7:05 A.M.</b>	
3 SEX <b>F</b> FEMALE		4. RACE <b>W</b> WHITE		5. DATE OF BIRTH MONTH DAY YEAR <b>02 17 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> - BALTIMORE MD.	
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. EMPLOYED ON (THE DAY OR MOST OF WORKING LIFE) <b>YES</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOCHSCHILD KOHN &amp; CO.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD</b> 13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>APT. 1-C #21215 3604 CHARLTH ROAD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>SOLOMON ALTFELD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EVA LEVIN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>-212-07-8868</b>		17. INFORMANT <b>PHILIP Z. ALTFELD 904 MD. TRUST. BLDG., CALVERT &amp; REDWOOD STS. #21202</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY Arrest</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>OVARIAN CARCINOMA</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/17 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that in this hospital attended the deceased from <b>11/23 19 79</b> to <b>11/23 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATED <b>11/23/79</b>	
22d. PHYSICIAN'S NAME (PRINT) <b>Jeffrey R. Agnew</b>		22e. ADDRESS <b>Sinai Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>NOV. 25, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAT ISRAEL</b>		23d. LOCATION <b>BALTIMORE</b> COUNTY <b>MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
NAME <b>6010 REISTERSTOWN RD.</b>		ADDRESS <b>BALTO., MD 21215</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Chlorophyll  $a$  and  $b$  content

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 0 8 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MADELINE A. ALVEY</b>			20. DATE OF DEATH MONTH DAY YEAR <b>NOV 29 79</b>		2b HOUR <b>12:55 PM</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 10 07</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTO. GEN'L HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salescladger</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Drugstore</b>
13a. STATE <b>MD.</b>			13b. COUNTY <b>-</b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>EMERY ABBOTT</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTYE HAHN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220221923</b>	17. INFORMANT ADDRESS <b>S. BALTO. GEN'L HOSP 3001 S. HANOVER ST</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>DAYS</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF BREAST</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to <b>11-28</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>11-28</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Gary A. Belaga, MD</b>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-29-79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY A. BELAGA, M.D.</b>			22e. ADDRESS <b>3001 S. HANOVER ST.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12/3/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greenmount Carroll Co. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>BURG-EE FUNERAL HOME</b>		ADDRESS <b>3631 FALLS RD</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1979</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 0 8 3	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>James Joseph Ament</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11-16-79</b>		2b. HOUR <b>7:00P<sup>M</sup></b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 18, 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Belair Convalescent Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tug Boat Fireman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4321 Mainfield Ave</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Ament</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Scheadrumpf</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>705-09-6527</b>		17. INFORMANT ADDRESS <b>Mrs Gertrude K Kromm Same</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>5999</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple Urinary Tract problems</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Parkinson's Disease; Dementia;</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <b>11/5/79</b> to <b>11/16/79</b> , that (I) (we) lost saw the deceased alive on <b>10/16/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Albert B. Bradley</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>11/16/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Albert B. Bradley, M.D.</b>				22e. ADDRESS <b>4900 Belair Rd. Balto., Md. 21206</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/20/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rodary</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard JRuck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR (SEE REGISTRAR'S SIGNATURE) <b>NOV 19 1979</b>		<b>Robert Bradley</b>					

James Joseph / Agent

11-12-72

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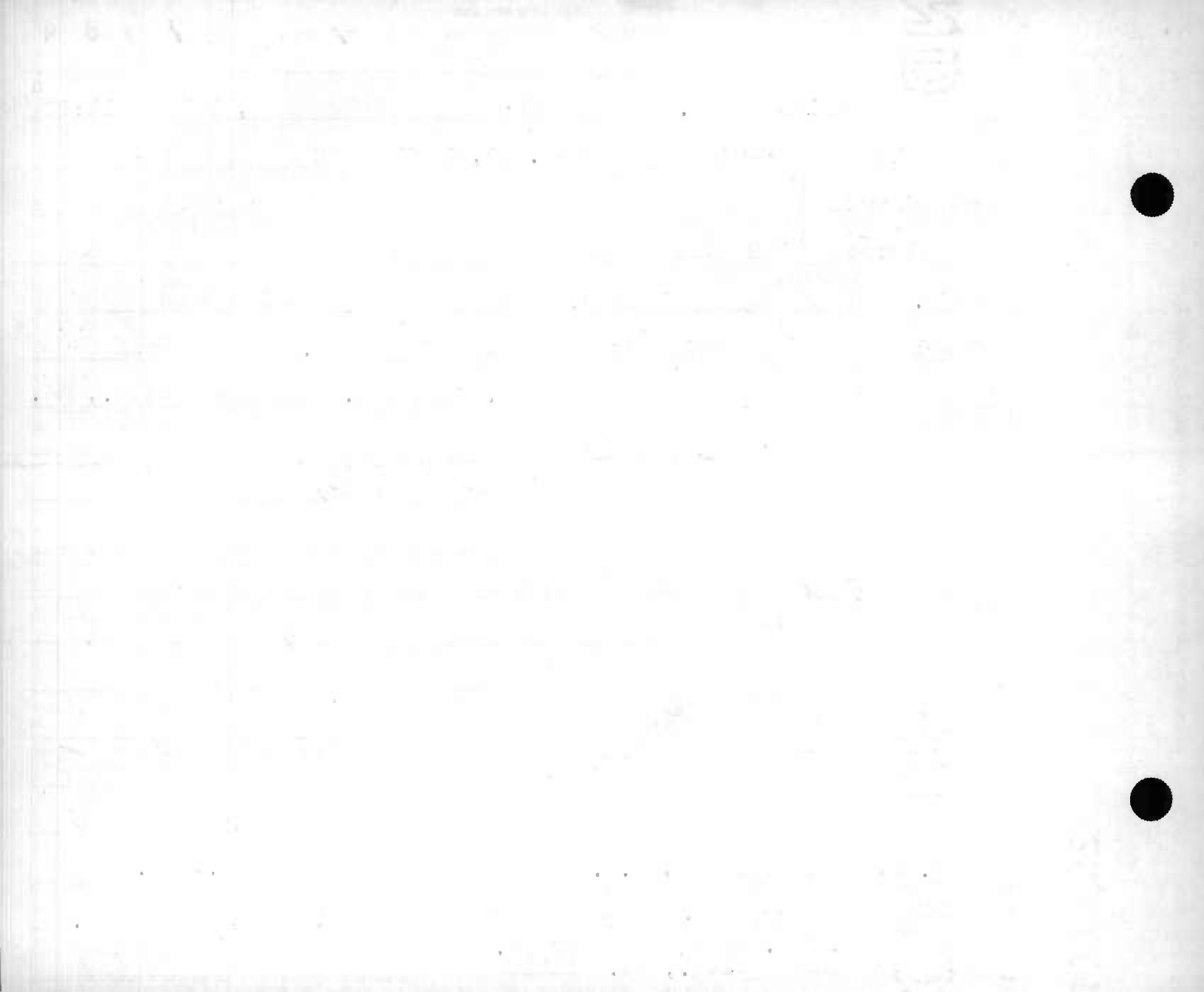
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2768 BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										79 27084	
1- FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>Hilma G. ANDERSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 4, 1979</b>			2b. HOUR <b>11:00M</b>			a		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Sept. 13, 1907</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>702 Hollen Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>702 Hollen Road</b>					
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Bedsworth</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leah R. Rose</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS <b>Mrs. Jeanne T. Smith Balto., Md.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COPD</b> <b>490-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recurrent Bronchitis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Yrs</b> <b>Yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Abdominal Aneurysm</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>July 14</b> , 19 <b>78</b> , to <b>OCT 24</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>OCT 20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <b>79</b>											
22b. SIGNATURE <b>Manankil</b>				DEGREE				22c. DATE SIGNED <b>11-5-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Roberto Manankil, M.D.</b>				22e. ADDRESS <b>6010 York Road Balto., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/4/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>					
24 FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Fitzroy Melroy</b>			
ADDRESS <b>4905 York Road Balto., Md. 21212</b>											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (J))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 27085

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
William BERNARD		Antkowiak						11 3 19 79		8:20 P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	OCT. 20 1909	70 YRS.			11 3 19 79		NEVER MARRIED		Baltimore City, MD.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
MARYLAND		USA		WIDOWED		CONSTRUCTION					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Church Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD		—		BALTIMORE		YES		115 S. CASTLE ST.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MARTIN		CZARNECKI		219-030649		MARTIN ANTKOWIAK		PART 1 DEATH WAS CAUSED BY:			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		IMMEDIATE CAUSE (a)			
NO		219-030649		MARTIN ANTKOWIAK		4292		Arteriosclerotic Cardiovascular Disease			
								DUE TO, OR AS A CONSEQUENCE OF			
								(b)			
								DUE TO, OR AS A CONSEQUENCE OF			
								(c)			
								PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES		NO					
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED							
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION							
NOT WHILE AT WORK		STREET, FACTORY, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion			
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
		X									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Virginia L. Dolan M.D.		Assistant		11/4/79							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Virginia L. Dolan, M.D.		111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
BURIAL		11/7/79		ST. ALPHONSUS CEM.		WOODSTOCK					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME		NOV 8 1979		[Signature]							
JOHN M WEBER & SONS INC		CHESTER ST									

1871

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 0 8 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John A. Artis</b>		2a. DATE OF DEATH MONTH <b>11</b> DAY <b>3</b> YEAR <b>79</b>		2b. HOUR <b>5:40 AM</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>19</b> YEAR <b>78</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>1</b> YRS. MONTHS <b>7</b> DAYS <b>1</b> HOURS <b>1</b> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland Hospital</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Infant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>—</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>L.</b> LAST <b>Artis</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Boydee</b> MIDDLE <b>—</b> LAST <b>Austin</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Patient's Chart</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>7469</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Respiratory arrest</b> (c) <b>congenital cardiac disease and chronic lung disease birth</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>w 45 minutes</b> <b>10 hours</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>—</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR <b>—</b> A.M. MONTH <b>—</b> DAY <b>19</b> P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>	21f. LOCATION STREET <b>—</b> CITY OR TOWN <b>—</b> COUNTY <b>—</b> STATE <b>—</b>	
22a. I certify that (1) (this hospital) attended the deceased from <b>11/3</b> <b>19</b> <b>79</b> , to <b>11/3</b> <b>19</b> <b>79</b> , that I <input checked="" type="checkbox"/> saw the deceased alive on <b>11/3</b> <b>19</b> <b>79</b> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> did not view the body after death.			
22b. SIGNATURE <b>Elizabeth Kay Spencer, M.D.</b>		DEGREE <b>MD</b>	22c. DATE SIGNED <b>11/3/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Elizabeth Kay Spencer, M.D.</b>		22e. ADDRESS <b>Dept. of Pediatrics, Univ. of Md. Hosp.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>11-7-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MARYLAND NATL PARK</b>	23d. LOCATION CITY OR TOWN <b>LAUREL</b> COUNTY <b>MARYLAND</b> STATE <b>MARYLAND</b>
24. FUNERAL DIRECTOR NAME <b>CHARLES A. RICE, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1979</b>	
ADDRESS <b>1300 E. TAW PLACE</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Kelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

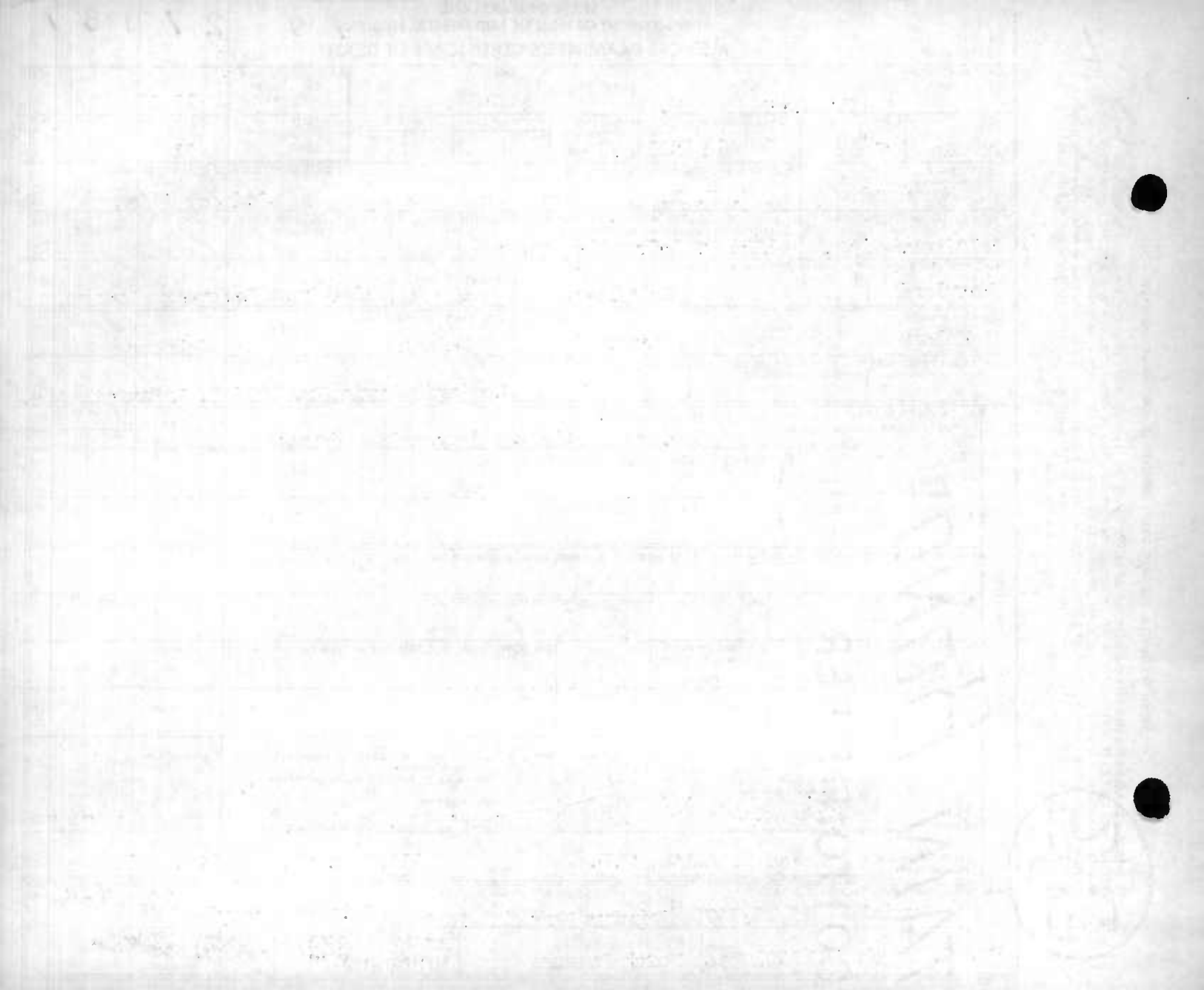


5521 2424

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE MEDICAL EXAMINER. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

0909 BP \_\_\_\_\_  
DHMH - 17  
(VRA15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7	9	2	7	0	8	7
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth H. Arvin										2a. DATE KNOWN OF DEATH ESTI- MATED MONTH DAY YEAR 11 17 1979				2b. HOUR M 3:05 P		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 6 1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 17 1979				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1226 E. LaFayette Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1226 East Lafayette Avenue						
14. FATHER'S NAME FIRST MIDDLE LAST Nelson Barnes						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena Johnson										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Benjamin Arvin, Jr. 1226 E. Lafayette Ave.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) M.D. Deputy Chief						DATE SIGNED 11/18/79						
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/21/1979		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Maryland						
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 East North Avenue						25a. DATE REC'D. BY REGISTRAR NOV 20 1979				25b. REGISTRAR'S SIGNATURE Dietrich Helmsky						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 0 8 8

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Anderson ASHER		MONTH DAY YEAR NOV 10 1979	
3. SEX		2b. HOUR	
male		11:13 A.M.	
4. RACE		6. AGE (IN YEARS LAST BIRTHDAY)	
Black		83 YRS.	
5. DATE OF BIRTH		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MONTH DAY YEAR 5-9-96		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Campbell Co. VA.		Baltimore City MD.	
7b. CITIZEN OF WHAT COUNTRY?		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
U.S.A.		Retired	
10. CITY OR TOWN OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore, Md.		Govt.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STREET ADDRESS	
Bon Secours Hospital		2247 E. Preston Street	
13a. STATE		13b. CITY OR TOWN	
Maryland		Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Joe Asher		FIRST MIDDLE LAST Mattie Asher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
YES		719-24-0542	
17. INFORMANT		ADDRESS	
Mary W. Asher		2247 E. Preston St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cerebral vascular accident			
436- DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) Hypertension			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE	
saw the deceased alive on NOV 19 79, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death.)		DEGREE M.D.	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS	
HUANG KUANG-YEN		Bon Secours Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		11-17-79	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Mt. National Home Park		Laurel Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	
William J. Spier 1639 N. Broadway		NOV 13 1979	
25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

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0804 BP

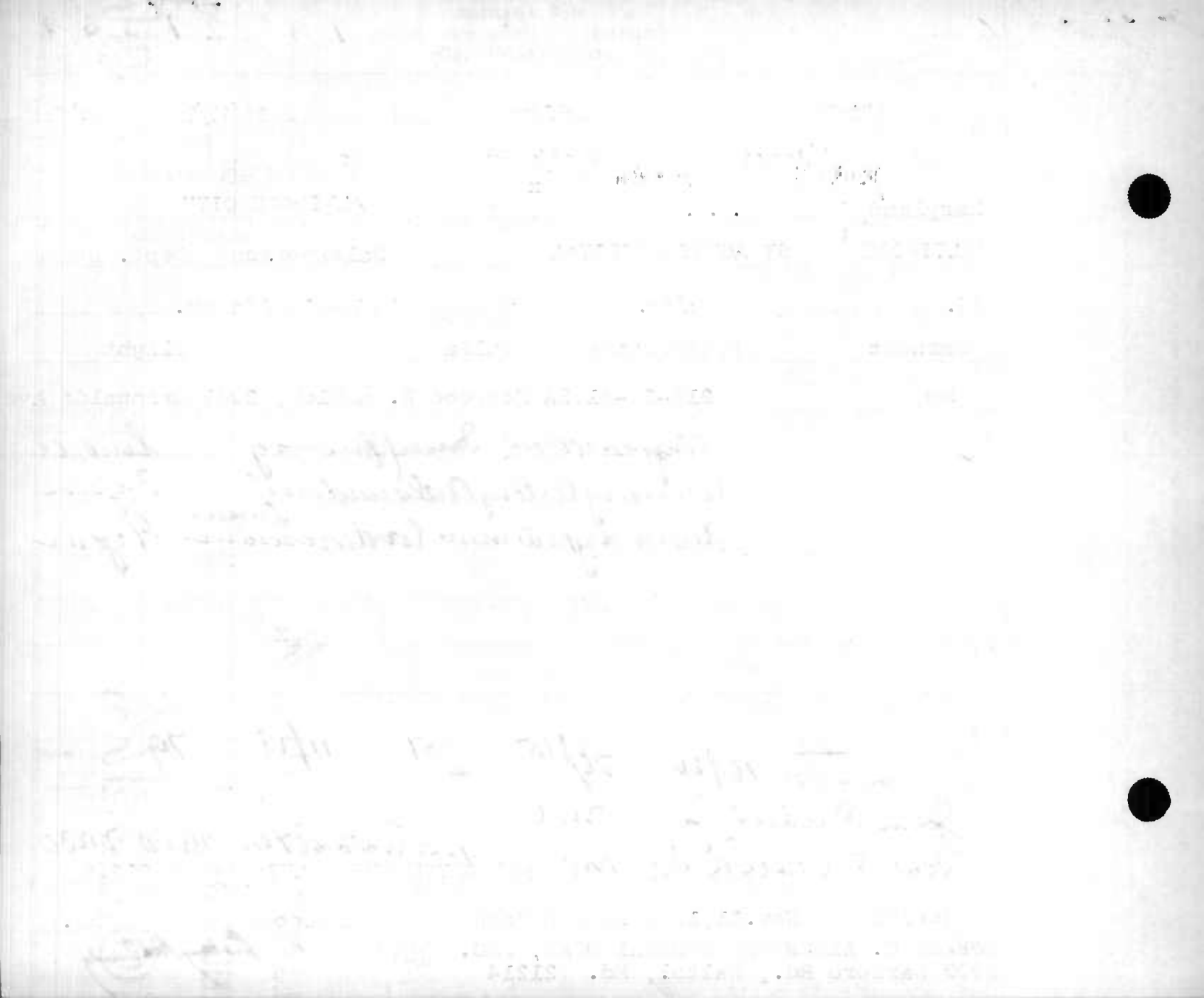


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 0 8 9	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Viola			FIRST MIDDLE LAST Ashley			2a. DATE OF DEATH MONTH DAY YEAR 11/18/79			2b. HOUR 8:10 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10/29/17		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2047 Grinnalds Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Earnest Rittershofer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Blight								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-28-4103A			17. INFORMANT ADDRESS Norwood R. Ashley, 2047 Grinnalds Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Insufficiency 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Severe Hypertensive Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 3 years 9 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 10/15/79 to 11/18/79, that (I) (we) last saw the deceased alive on 10/18/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE John P. Uraluck Jr			DEGREE MD			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN P. URALUCK JR MD			22e. ADDRESS 1227 WASHINGTON BLVD 21230 900 CATON AVE BALTIMORE MD 21229								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 21, 1979		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.				
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltol., Md. 21214						25. DATE REC'D. BY REGISTRAR NOV 20 1979		25b. REGISTRAR'S SIGNATURE [Signature]			





FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 2 7 0 9 0	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Abner Carl ASKEW		11-8-79		8 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))		
Male	White	10-14	65 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U.S.A.		Balto. City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Balto.	1415 W. Balto. St.		Café		Café Co.
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Md.			Balto.	1415 W. Balto. St. - 21223	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
George Buck ASKEW		Lelia Beatrice HOPKINS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214-01-1622		Frank L. Davis h. 1338 Washington Blvd. 21238	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST.</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>ASCVD +</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> , 19 <u>78</u> , to <u>9/24</u> , 19 <u>78</u> , that (I) (we) last saw the deceased alive on <u>8/24</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
INDER SINGH				11/8/78	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
INDER SINGH		2301 Annapolis Road Balto. Md. 21220			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
burial		11-12-79	Linden Park Cem.		Baltimore Md.
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
John J. Conner		508 E. 2122		NOV 13 1979 Rusty McCready	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 2 7 0 9 1					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EARNEST ATKINSON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-26-79</b>			2b. HOUR <b>12 37 PM</b>		
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-31-24</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>55</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALT.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV. OF MD. HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DISABLED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Physician</b>		
13a. STATE <b>MD</b>					13b. COUNTY <b>BALT. CITY</b>		13c. CITY OR TOWN <b>BALT. CITY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE <b>BEN ATKINSON</b>					15. MOTHER'S MAIDEN NAME MIDDLE LAST <b>ANNIE UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT ADDRESS <b>AMBULANCE CREW</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARRHYTHMIA</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV. 26</b> , 19 <b>79</b> , to <b>NOV 26</b> , 19 <b>79</b> , that (I) (we) lost <b>saw the deceased give on above (I/we) (did) (did not) view the body after death.</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE <b>Edward Peter Koram</b>					DEGREE <b>MD.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/26/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD PETER KORAM MD.</b>					22e. ADDRESS <b>UNIV. OF MD. HOSP.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>02-1-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBITUS MEM. PK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR <b>PHILLIPS</b>					ADDRESS <b>1721-27 N. MONROE ST.</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>NOV 28 1979</b>			

MEDICAL CERTIFICATION

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

7 9 2 7 0 9 2

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JEROME LESTER AULTON</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>24</b> YEAR <b>79</b>			2b. HOUR <b>4:56p</b> M	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>17</b> YEAR <b>34</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY,</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>LUTHERAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CHAUFFEUR</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST <b>EARL</b> MIDDLE <b>AULTON</b>				15. MOTHER'S MAIDEN NAME FIRST <b>HAZEL</b> MIDDLE <b>MATTHEWS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO <b>215304581</b>		17. INFORMANT ADDRESS <b>VAMC Medical Records 3900 Loch Raven Blvd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>UNRESECTABLE PHARYNGEAL CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SIX MONTHS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SIX MONTHS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>NONE</b>							
19a. DATE OF OPERATION <b>JUNE 1979</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>NONE 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>NONE</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 1</b> 19 <b>79</b> , to <b>NOVEMBER 23</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>23 NOVEMBER 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J. Houston Bosley III</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>25 NOVEMBER 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. HOUSTON BOSLEY</b>				22e. ADDRESS <b>LOCH RAVEN VAMC BALTIMORE 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-30-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NAT. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. BALTO. MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>ELICKSON FUNERAL HOME</b>		ADDRESS <b>1129 N. CAROLINE</b>		25. DATE RECEIVED BY REGISTRAR <b>NOV 27 1979</b>		25b. SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 0 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Peter</b>			FIRST MIDDLE LAST <b>BAGINSKI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 1 1979</b>			2b. HOUR <b>8:30A M</b>		
3 SEX <b>Male</b>			4 RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 25, 1907</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Exxon</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS <b>4212 Cottman Ave. 21206</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Baginski</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva Lewandowski</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>214-01-5654</b>		
16c. (IF YES, GIVE WAR OR DATES) <b>WWII</b>			17 INFORMANT ADDRESS <b>Catherine Baginski (wife) same</b>								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Liver Failure And Ascites</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastrointestinal Bleeding</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>October 27</b> , 19 <b>79</b> , to <b>November 1</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>November 1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Krikor Tatoyan</b>						DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>11-1-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Krikor Tatoyan, M.D.</b>						22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5 Nov 79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md. Baltimore</b>		
24 FUNERAL DIRECTOR NAME <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane Balto. Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 2 1979</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7 9 2 7 0 9 4				REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET ELINOR BAHKE			2a. DATE OF DEATH MONTH DAY YEAR 11 28 79			2b. HOUR 9 <sup>00</sup> P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS Village of Cross Keys Hamill Ct. Apts. Apt. #26-21210			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Justice Henry Dimmling				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura M. Lamp					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-46-2760		17. INFORMANT ADDRESS Mr. George Wm. Bahlke-Hamill Ct. Apts.-21210					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary Arrest</u> 1952 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diffuse Abdominal Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 1/2 yrs.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 11/28/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Obstruction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> , 19 <u>79</u> , to <u>11/28</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Carlo J. Valenziano</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 11/28/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLO J. VALENZIANO M.D.				22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 1, 1979		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland-21208			
24. FUNERAL DIRECTOR NAME Henry Sander & Sons, Baltimore, Md.-21213				25a. DATE REC'D. BY REGISTRAR NOV 30 1979		25b. REGISTRAR'S SIGNATURE <i>John H. Kelly</i>			



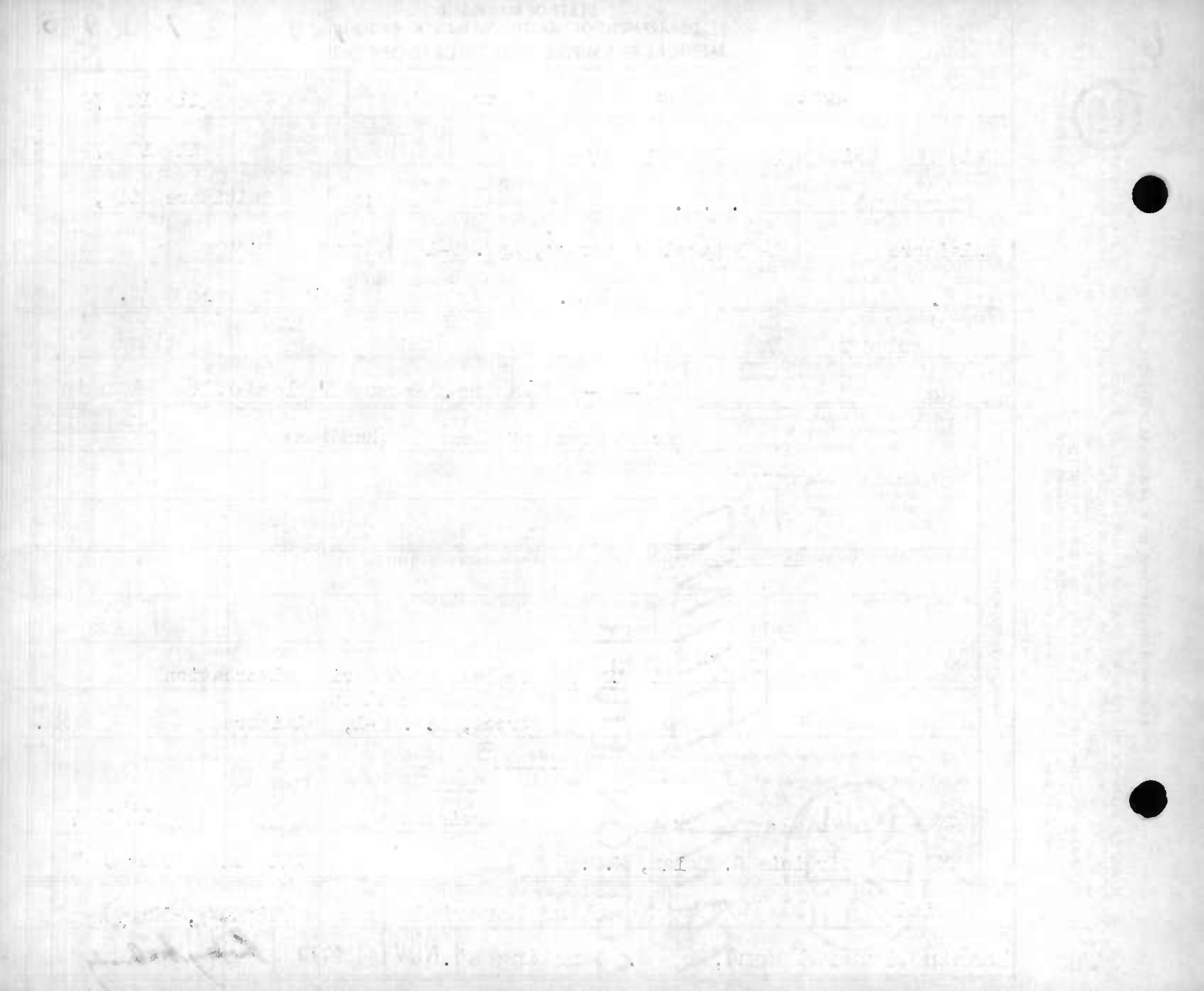
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR	
CARRIE		V		BAKER		11-28-79		8:00pm	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR	
Female		Black		MONTH DAY YEAR 1 2 1922		57 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
S. C.		USA				Balto. City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Balto.		Church Home Hospital		Housewife					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS			
13a. STATE				13c. CITY OR TOWN		13b. STREET ADDRESS			
Md				Balto.		1334 E. Fayette Street			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
Alexander				Viola		Bryant			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				215 22 2307		Emory Baker 1035 Orleans Street Apt 3F			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CARCINOMA OF THE LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>BRAIN METASTASES, RENAL FAILURE ELECTROLYTE EMBALANCE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-27-</u> <u>19</u> <u>79</u> to <u>11-28-</u> <u>19</u> <u>79</u> , that (I) <u>we</u> last saw the deceased alive on <u>11-28-</u> <u>19</u> <u>79</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				<u>11/28/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
DR. ADOLFO LOPEZ				CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		12-3-79		Mt. Auburn Cemetery		Baltimore		Maryland	
24. FUNERAL DIRECTOR NAME				25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE			
Isaiah L. Brown & Son PA 1913 W. Balto. St.				NOV 30 1979					



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER OF THE REASON FOR THE DELAY.  
**TO FUNERAL DIRECTOR:** THIS CERTIFICATE MUST BE FILED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER OF THE REASON FOR THE DELAY.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9		27096			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold Lee Baker						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 11 12 19 79			2b. HOUR M 2:14 P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 6 31		6. AGE (IN YEARS) LAST BIRTHDAY 47 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1403 Angelsea Street, Apt. T-1				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) truck driver			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (# IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1403 Angelsea St.			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Baker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Hand							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 212-28-9996		17. INFORMANT ADDRESS Mrs. Norma D'Alesio, 164 Ritchie Hy					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest (handgun) 9650 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 2 P.M. 11 12 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot during altercation							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1403 Angelsea Street, Apt. T-1, Baltimore Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) Assistant M.D.				DATE SIGNED 11/13/79			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/16/79		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Hk		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Zannino Funeral Home, 263 S. Conkling St.				25a. DATE REC'D. BY REGISTRAR NOV 14 1979		25b. REGISTRAR'S SIGNATURE [Signature]					







11012

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

STATION NO. \_\_\_\_\_ DATE \_\_\_\_\_  
CULTIVATOR \_\_\_\_\_

CULTURE NO. \_\_\_\_\_  
LOCALITY \_\_\_\_\_

PLANT NAME \_\_\_\_\_  
SPECIES \_\_\_\_\_

COLLECTOR \_\_\_\_\_  
LOCALITY \_\_\_\_\_

PLANT NAME \_\_\_\_\_  
SPECIES \_\_\_\_\_

COLLECTOR \_\_\_\_\_  
LOCALITY \_\_\_\_\_

PLANT NAME \_\_\_\_\_  
SPECIES \_\_\_\_\_

COLLECTOR \_\_\_\_\_  
LOCALITY \_\_\_\_\_

PLANT NAME \_\_\_\_\_  
SPECIES \_\_\_\_\_

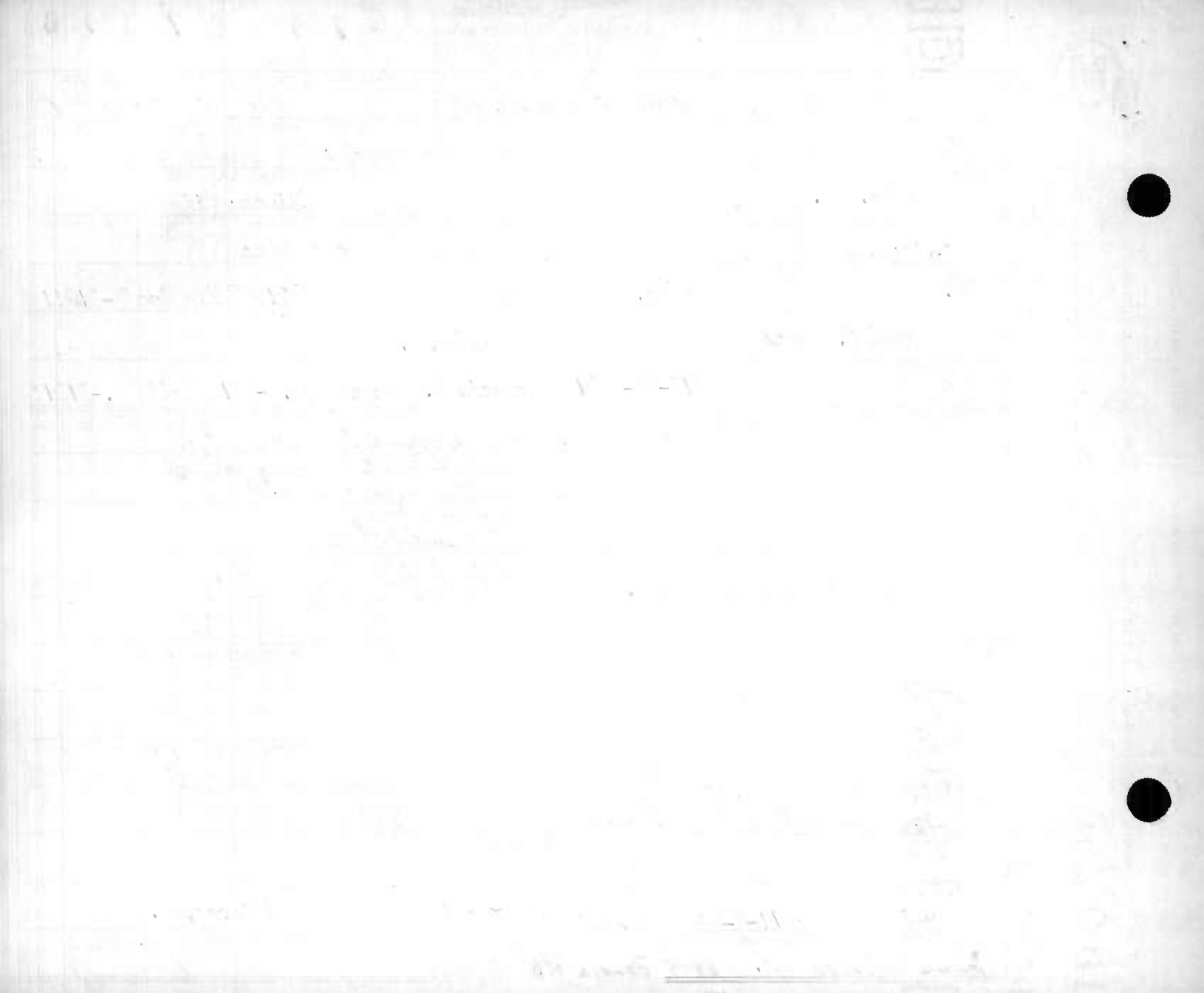
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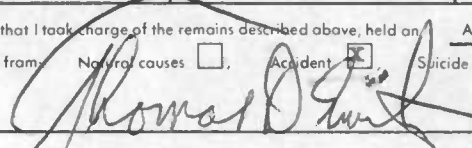
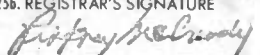
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



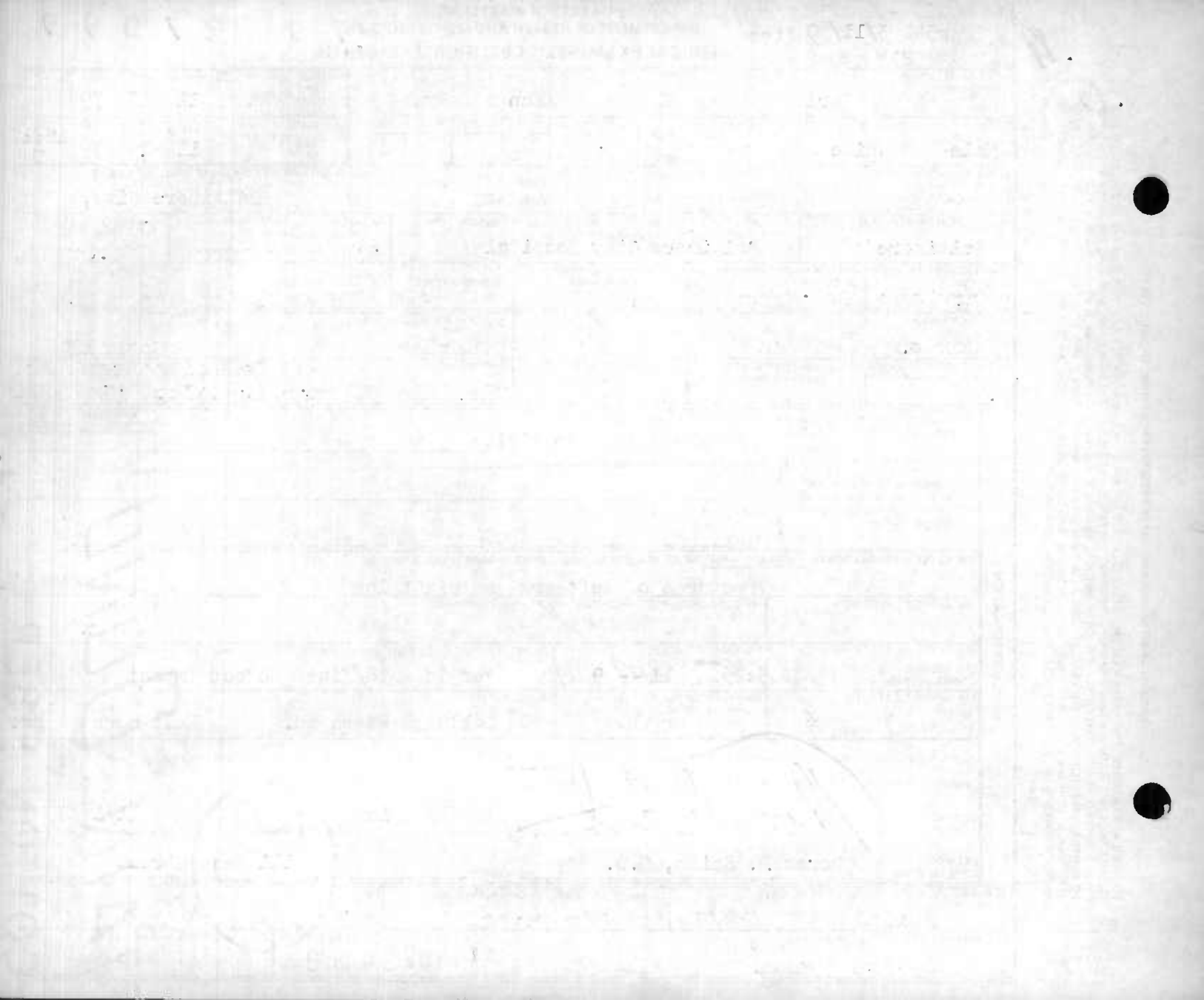
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 27 09 8	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Beatrice Mary Bandell						11 2 79			1304 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
F		W		1 4 21		58 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Balto. Md.		USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Fed Hill Nursing Center						Home Maker			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. INSIDE CITY LIMITS?			13b. STREET ADDRESS					
13a. STATE			13b. COUNTY			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4210 Falls Road -21211		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Earl B. Myers			Helen A.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
(YES <input checked="" type="checkbox"/> OR UNKNOWN)			212-76-4041			Francis J. Bandell Sr. -4210 Falls R. -21211					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest, secondary to asphyxiation of food</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asphyxiation of stomach &amp; neck of</u>											
(c) <u>Dehydrated mottled</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Fracture left hip mental deterioration</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/28</u> , 19 <u>79</u> , to <u>11/2</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>10/18/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Samuel Rubin MD			MD								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			11-5-79		Moreland Memorial		Baltimore, Md.				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOHN C. MILLER Inc.						6415 BELAIR RD		NOV 0 1979		[Signature]	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PMA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS-301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>Earl R. Bangs, Sr.</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 15 1979</b>		2b. HOUR M <b>12:12</b> P <b>M</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 14 1929</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>50</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 15 1979</b>		2d. HOUR M <b>12:12</b> P <b>M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plant Manager</b>		12b. KIND OF BUSINESS <b>Cleaner Hanger Co.</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>909 Oakleigh Beach Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gordon O. Bangs</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Gosnell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-24-9230</b>		17. INFORMANT <b>909 Oakleigh Beach Rd. Virginia S. Tumblin-Balto. MD 21222</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Alcoholic hepatitis</b> <b>5711</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Fractures of left arm and right leg</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>5:25 P.M. 11/8/79</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver in auto/fixed object impact</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>driveway</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>908 Oakleigh Beach Rd. Baltimore Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 			TITLE (SPECIFY) <b>Deputy Chief</b>			MEDICAL EXAMINER			DATE SIGNED <b>11/16/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>			ADDRESS <b>111 Penn Street</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/19/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Harford MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1979</b>		25b. REGISTRAR'S SIGNATURE 			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 0 0

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARTIN Austin BANKERT			2a. DATE OF DEATH MONTH DAY YEAR 11 30 79			2b. HOUR 2 A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-27-07		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Financial Sec.		12b. KIND OF BUSINESS INDUSTRY Chev. Co. A.D. Anderson		
13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4010 Woodley Road, Ellicott City 21043	
14. FATHER'S NAME FIRST MIDDLE LAST Calvin E. Bankert			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Yingling							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 215-10-4841		17. INFORMANT ADDRESS Elisabeth Ward Bankert, 4010 Woodley Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 2252 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sepsis</u> (c) <u>Meningitis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>subdural hematoma</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>M. J. V.</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 11/30/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORTFOSIS, FLORIAN				22e. ADDRESS Mary Host						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 12/3/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Witzke Funeral Home of Catonsville, P.A. 21228				25a. DATE REC'D. BY REGISTRAR DEC 3 1979		25b. REGISTRAR'S SIGNATURE <u>Barry H. ...</u>				





NOTICE

NOTICE

NOTICE

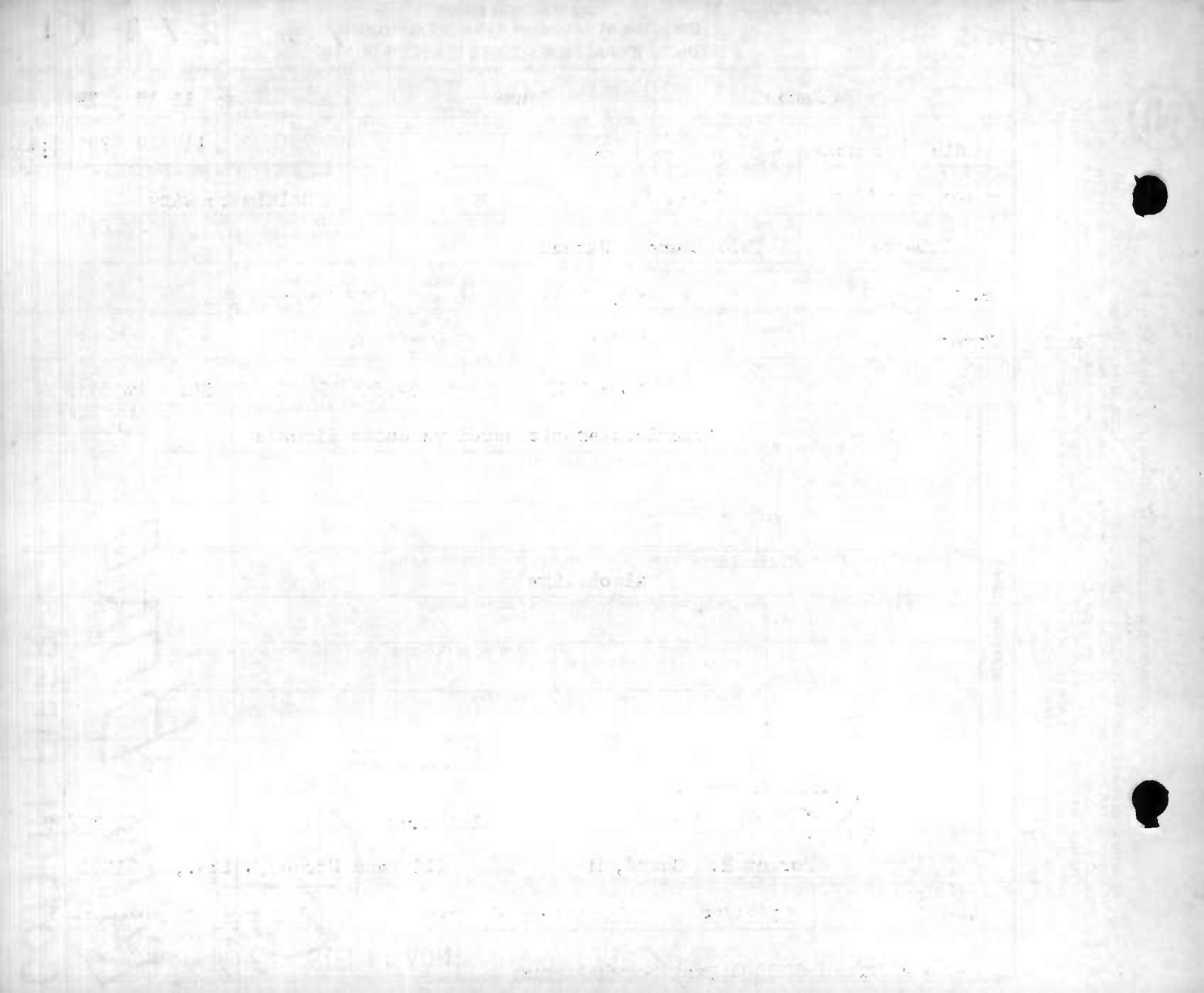
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1000. 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1502 BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		21. HOUR	
James		Banks						11		18		19		79				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		22. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		23. HOUR	
male	black	2 5 99		80 YRS.						11		19		79				7:45 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH										MD.	
North Carolina		U. S. A.		WIDOWED		DIVORCED		Baltimore City											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		1814 Laurens Street																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1814 Laurens St.											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
James		Classy		218-10-4145		George Banks		464 W. 152 St. New York											
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16c. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		218-10-4145		George Banks		464 W. 152 St. New York													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART I DEATH WAS CAUSED BY:		Arteriosclerotic cardiovascular disease																	
4292		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		Alcoholism																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		11/20/79													
EXAMINER'S NAME (TYPE OR PRINT)		Hormez R. Guard, MD		ADDRESS		111 Penn Street, Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Burial		11/24/79		King Memorial Park		Baltimore		Co., Maryland											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Wm. C. March		F/H 1101 East North Avenue		NOV 21 1979		Fitzpatrick													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH ESTIMATED		3. MONTH DAY YEAR		4. HOUR	
1. DECEASED NAME		2b. DATE KNOWN OF DEATH ESTIMATED		3. MONTH DAY YEAR		4. HOUR	
Stanley		11 16 1979		11 16 1979		M	
5. SEX	6. RACE	7. DATE OF BIRTH	8. AGE (IN YEARS)	9. IF UNDER 1 YR.	10. IF UNDER 24 HRS.	11. DATE PRONOUNCED DEAD	12. HOUR
Male	Black	11/26/1921	58 YRS.			11 16 1979	7:41P
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	14. CITIZEN OF WHAT COUNTRY?	15. MARRIED	16. NEVER MARRIED	17. WIDOWED	18. DIVORCED	19. BALTIMORE CITY OR COUNTY OF DEATH	
1,29,21	U.S.A.					Baltimore City, MD.	
20. CITY OR TOWN OF DEATH	21. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	22. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		23. KIND OF BUSINESS OR INDUSTRY			
Baltimore City	804 N. Gilmore St.	Shadler					
24. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	25. STATE	26. COUNTY	27. CITY OR TOWN	28. INSIDE CITY LIMITS?	29. STREET ADDRESS		
304 N. Gilmore St.	MD.	Balto		YES	804 N. Gilmore St		
30. FATHER'S NAME	31. MOTHER'S MAIDEN NAME	32. INFORMANT		33. ADDRESS			
George S. Shadler	Ada Barber	237 W. Collington					
34. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	35. SOCIAL SECURITY NO.	36. INFORMANT		37. ADDRESS			
2	319-05-6821	237 W. Collington					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER							
ACTUAL SIGNATURE		DATE SIGNED		11/17/79			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St. Balto., MD.			
Thomas D. Smith, M.D.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		23e. STATE		
Burial	11/21/79	West View	Baltimore		MD.		
24. FUNERAL DIRECTOR NAME	ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
William H. Carroll	Balto. MD		NOV 26 1979				

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27103		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) <b>David W. Barbour</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 3 1979</b>		2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 28 1952</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>27</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital (STU)</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Medical Technician</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Laplace</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>300 Harford Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nelson L Barbour</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgia Warren</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Unknown</b>			16b. SOCIAL SECURITY NO. <b>219 58 8870</b>			16c. ADDRESS <b>Star Route 1, Box 12711, Welcome, Md</b> <b>William Brensinger, Step-Father</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blunt injury to head, trunk, and legs</b> 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>? P.M. 10 28 1979</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 10 28 1979</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Pedestrian struck by auto</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Ave. &amp; Rt. 301 Old Washington Charles, Md.</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>			TITLE (SPECIFY) <b>Assistant</b>			MEDICAL EXAMINER			DATE SIGNED <b>11/4/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>			ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov 6 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland</b>				
24. FUNERAL DIRECTOR'S NAME <b>Robert E Wilhelm</b>						ADDRESS <b>Suitland Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 09 1979</b>			
						25b. REGISTRAR'S SIGNATURE <b>John J. McCreedy</b>						

MEDICAL CERTIFICATION



APR 20 1979

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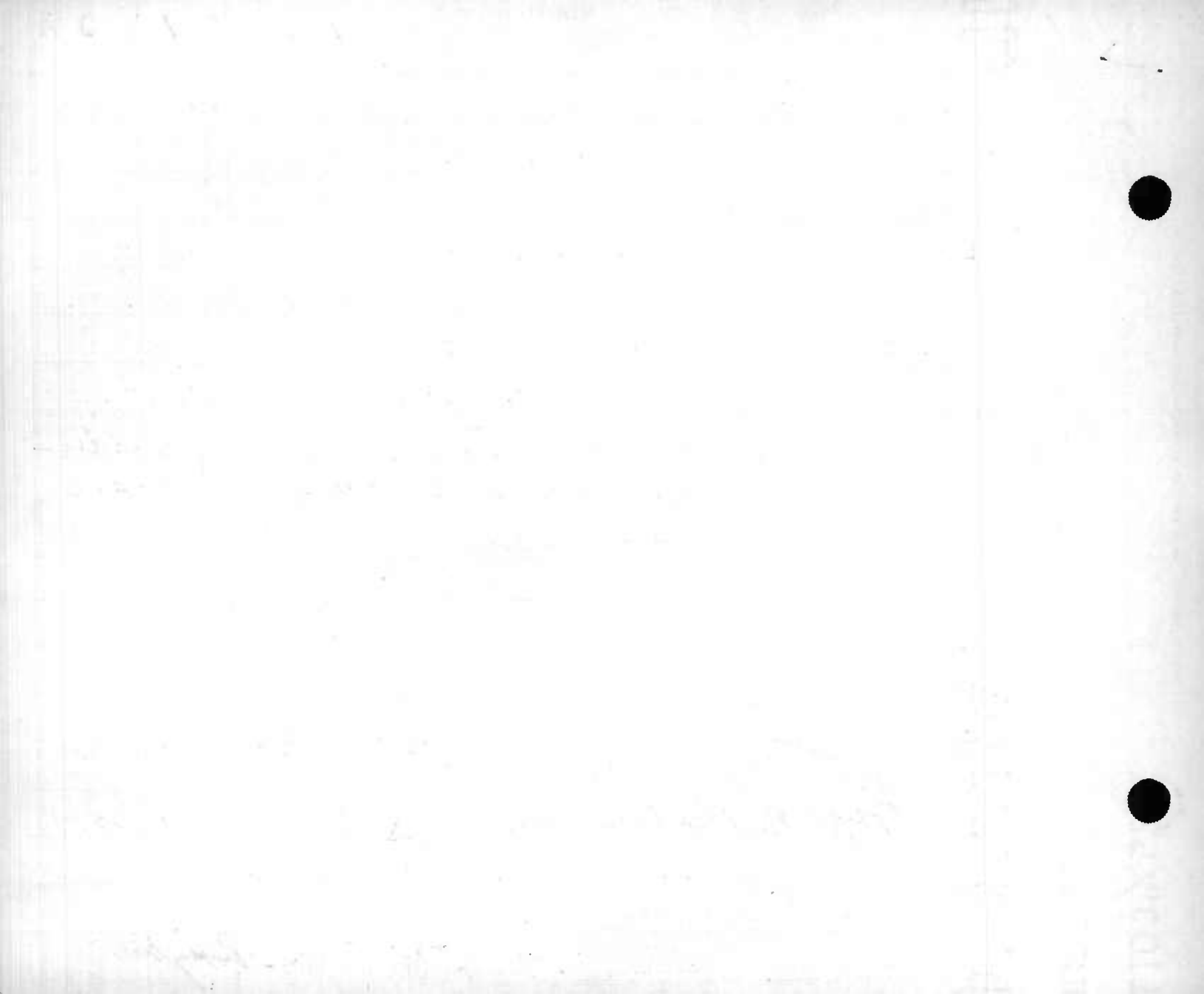


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) CHARLES BARD					2a. DATE OF DEATH NOVEMBER 27, 1979			2b. HOUR 1:15P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH SEPT. 2, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6001 PARK HEIGHTS AVE. APT 3E				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6001 PARK HEIGHTS AVE. APT. 3E	
14. FATHER'S NAME FIRST MIDDLE LAST RUBIN BARD					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE ROTHENBERG				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212- 09-9069		17. INFORMANT 11511 4 <sup>TH</sup> FLOOR PENNY LANE DR. EARL KLOZE FAIRFAX STATION, VA. 22015					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL ISCHEMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>HEART DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>YEARS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>75</u> , to <u>11/27</u> , 19 <u>75</u> , that (I) (we) lost saw the deceased alive on <u>11/19</u> , 19 <u>75</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (you) (we) did not view the body after death.									
22b. SIGNATURE <u>Joseph C. Matchar MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>11/28/75</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH MATCHAR, M.D.				22e. ADDRESS 3635 OLD COURT RD. (21208)					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/29/79		23c. NAME OF CEMETERY OR CREMATORY BETH ISAAC ADATH ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS.				6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)		25a. DATE REC'D. BY REGISTRAR DEC 5 1979		25b. REGISTRAR'S SIGNATURE <u>Henry Kel...</u>	



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

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FOR  
1- STATE  
REGISTRAR

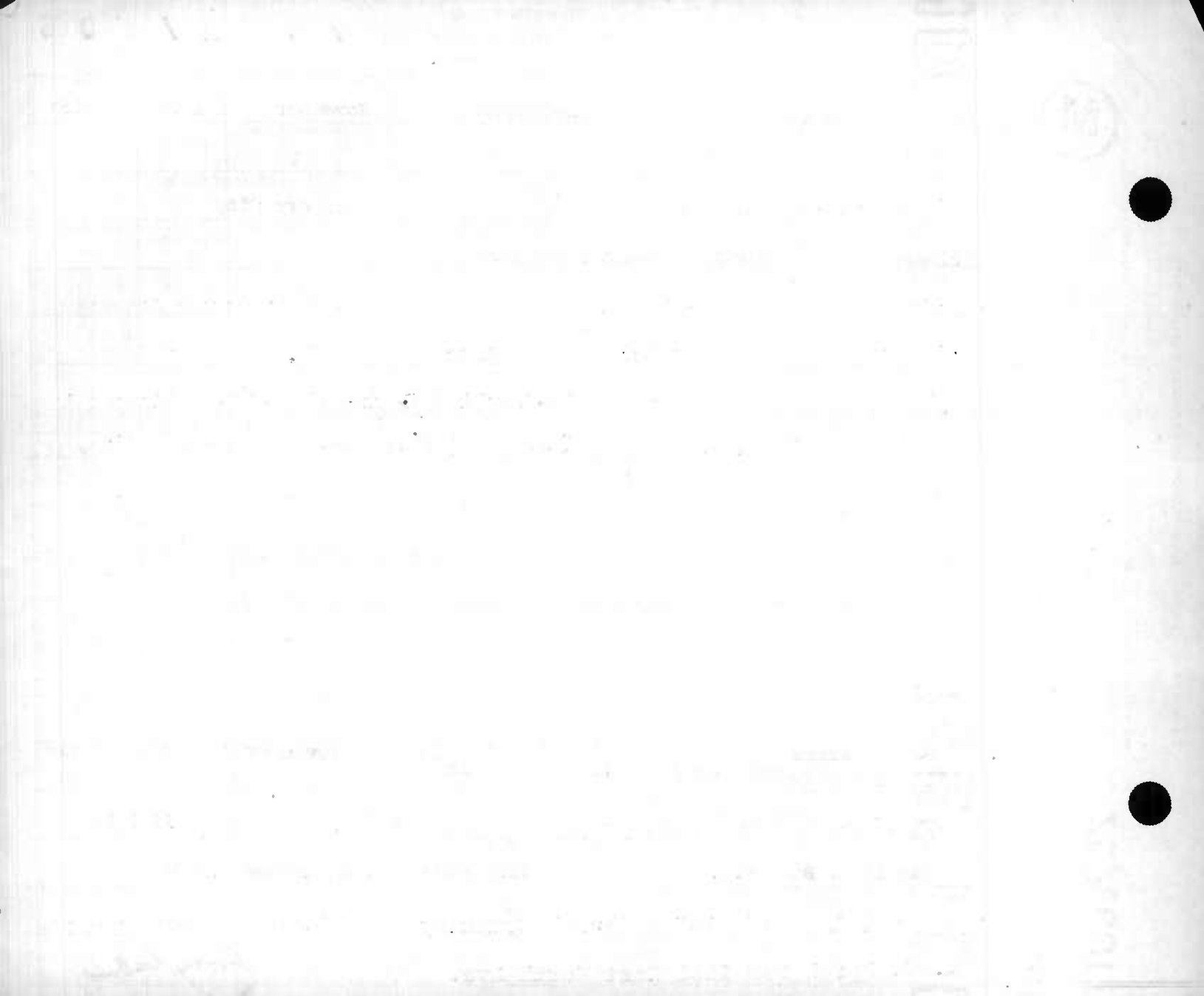
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Darnell BARKSDALE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 1 1979</b>			2b. HOUR <b>7:25A</b> M			
3 SEX <b>Male</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 25 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1208 Oakhurst Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Chaney Barsdale</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora L. Dunlap</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>247-44-6032</b>		17. INFORMANT ADDRESS <b>Gerline Barksdale 1208 Oakhurst Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Cancer (Adenocarcinoma)</b> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (personnel) attended the deceased from <b>Oct 1 19 77</b> to <b>November 1 19 79</b> , that (I) (we) last saw the deceased alive on <b>November 1 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Harold B. Bob</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11-1-79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold B. Bob, M.D.</b>			22e. ADDRESS <b>7220 Park Heights Avenue 21208</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/5/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton, South Carolina</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 2 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR		7 9 2 7 1 0 6 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) George J. Barksdale, Jr.						2a. DATE OF DEATH MONTH DAY YEAR 11 13 79		2b. HOUR M		
3 SEX M		4 RACE B		5 DATE OF BIRTH MONTH DAY YEAR 6 15 22		6 AGE (IN YEARS LAST BIRTHDAY) 57		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10 CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3031 Mondawmin Aven	
14. FATHER'S NAME FIRST MIDDLE LAST George Barksdale, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Jackson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII 215-14-9622		17. INFORMANT ADDRESS Margaret Barksdale 3031 Mondawmin A					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>11-13</u> , 19 <u>79</u> , to <u>11-13</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Sayumi B. Elma</u> MD					DEGREE MD			22c. DATE SIGNED 11-15-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BAYANI B. ELMA MD					22e. ADDRESS 3823 ENTERA AVE Balt Md. 21224					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/17/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H					ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR NOV 19 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McBrady</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 27107				
1. FOR STATE REGISTRAR										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Lottie</b>					FIRST MIDDLE LAST <b>BARNES</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11 11 79</b>			2b. HOUR <b>1115 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 8 1912</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>			IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		IF UNDER 24 HRS HOURS MIN. <b>11 15</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.							
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>U. OF MARYLAND HOSPITAL</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>905 SARATOGA ST</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Perry Smith</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lottie</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>217-03-8103</b>		17. INFORMANT ADDRESS <b>Shirley Reason 3663 Wabash Avenue</b>								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> <b>436-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pneumonia</b>														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 20</b> 19 <b>79</b> , to <b>NOV 11</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>NOV 11</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>L. Gaynes, MD</b>								DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/11/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LYNNE GAYNES</b>								22e. ADDRESS <b>U. OF MARYLAND HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/16/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto Nat. Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Maryland</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 East North Avenue</b>								25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>		25b. OFFICIAL'S SIGNATURE <b>[Signature]</b>				



100-112-101

RECEIVED  
JAN 12 1964

TO: MR. B. H. ...

FROM: ...

100-112-101

100-112-101

100-112-101

100-112-101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

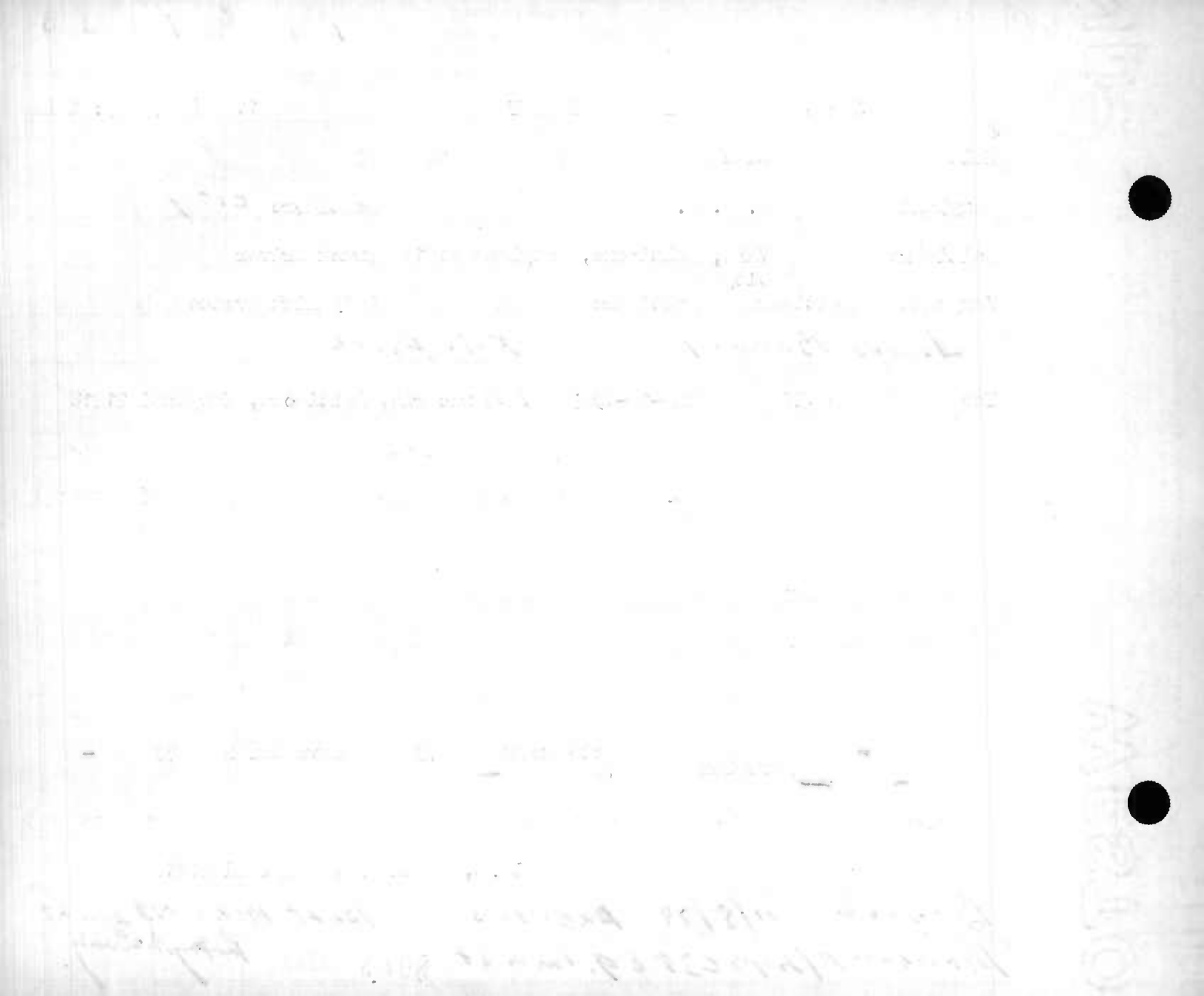
FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 0 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES HENRY BARNEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 4 79</b>			2b. HOUR <b>9:32 A.M.</b>						
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 8 26</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>53</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS HOURS MIN <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, Baltimore, Maryland 21218</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2635 Kirk Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Bannoy</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kate Fuero</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>220-14-1905</b>		17. INFORMANT ADDRESS <b>VAMC records, Baltimore, Maryland 21218</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA - SEPSIS</b> 2030 DUE TO, OR AS A CONSEQUENCE OF (b) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 mos</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION <b>NONE</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from <b>October 26</b> , 19 <b>79</b> , to <b>November 4</b> , 19 <b>79</b> , that (we) lost saw the deceased alive on <b>November 4</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.												
22b. SIGNATURE <b>Christine L. Commerford MD.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>Nov. 4, 1979</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHRISTINE L. COMMERFORD, MD</b>						22e. ADDRESS <b>VAMC, Baltimore, Maryland 21218</b>						
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) <b>BURIAL</b>			23b. DATE <b>11/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARNDTUS</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD 21217</b>				
24. FUNERAL DIRECTOR NAME <b>Marshall A. Bays</b>						ADDRESS <b>638 S. G. Lane St</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1979</b>		25b. SIGNATURE <b>[Signature]</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		7 9 27109	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST Lillian M. Barranco		MONTH DAY YEAR HOUR 11 20 19 79 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Female	White	MONTH DAY YEAR Feb 4, 1896	LAST BIRTHDAY 83 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA	WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore City, MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5408 Tramore Road	Housewife	-----
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland	-----	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT ADDRESS	
FIRST MIDDLE LAST Joshua Robinson	FIRST MIDDLE LAST Margaret Schmidt	Joseph S. Barranco 5408 Tramore Rd. 21214	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No	218-52-1197	Joseph S. Barranco 5408 Tramore Rd. 21214	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED	
Virginia L. Dolan M.D.	Assistant	11/21/79	
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS		
Virginia L. Dolan, M.D.	111 Penn Street		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Nov 23, 79	Baltimore Cemetery	Baltimore, Maryland
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Dippel Brothers, Inc.	7110 Belair Rd. 21206	NOV 23 1979	Ruby Kennedy

TO THE  
HONORABLE  
THE SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.

DEAR SIR:  
I have the honor to acknowledge the receipt of your letter of the 28th inst. in relation to the matter of the proposed purchase of the land for the proposed site of the new building for the Navy Department, and in reply to inform you that the same has been referred to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours very truly,  
J. D. LONG

Very truly,  
J. D. LONG  
Secretary of the Navy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of force.

Item #5 phone call w/Fun. Home STATE OF MARYLAND									
FOR 12/3/79 rc DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- STATE REGISTRAR CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edward Barrett</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 15, 1979</i>		2b. HOUR <i>5:39 PM</i>		
3. SEX <i>Male</i>		4. RACE <i>Cauc</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 31 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>69</i>		7. UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Salesman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Esskay</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN <i>Md. Balto. Towson</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1000 E. Joppa Rd. Apt. 213</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Barrett</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Weir</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>213-03-91114</i>		17. INFORMANT ADDRESS <i>Mrs. Catherine Barrett Joppa Rd.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <i>4289</i> IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pulmonary Failure</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 minute</i> <i>1 year</i> <i>1 year</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from <i>Nov 8</i> , 19 <i>79</i> , to <i>Nov 15</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>Nov 15</i> , 19 <i>79</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Lawrence Mills, Jr. MD</i>				DEGREE <i>MD</i>				22c. DATE SIGNED <i>11/15/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lawrence Mills, Jr. MD</i>				22e. ADDRESS <i>5601 Loch Raven - Good Samaritan Hospital</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-19-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Cem.</i>		23d. LOCATION CITY OR TOWN <i>Balto.</i>		COUNTY <i>Balto.</i> STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc.</i>				ADDRESS <i>6415 Belair Rd.</i>		25a. DATE REGD. BY REGISTRAR <i>NOV 19 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR	
FIRST MARY MIDDLE COFIELD LAST BARRETT.					MONTH 11 DAY 23 YEAR 79.			2:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
Female		White		MONTH 11 DAY 18 YEAR 1902		77 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Baltimore 177 MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Long Green Nursing Home				Hwf			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE Md. 13b. COUNTY Balto 13c. CITY OR TOWN Baltimore					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16506 Dubbs Rd.		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST John Naylor					FIRST MIDDLE LAST Frances Bull				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 220-12-5108		17. INFORMANT ADDRESS		
							Clyde M. Cofield Sparks, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral A-S.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 da. 24 hr. 5 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 1977</u> to <u>Nov 23 19 79</u> , that (I) <u>(attending)</u> saw the deceased alive on <u>11/20 19 79</u> , and that in (my) <u>(attending)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(attending)</u> (did not) view the body after death.									
22b. SIGNATURE Norman R. Freeman MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN R. FREEMAN						22e. ADDRESS 116 21st St, Baltimore Md 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Nov. 27, 79		Mt. Zion Cemetery		Upperco, Balto. Co. Md.		
24. FUNERAL DIRECTOR Eline Funeral, Home Hampstead, Md. 21074						25a. DATE REC'D. BY REGISTRAR NOV 29 1979		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

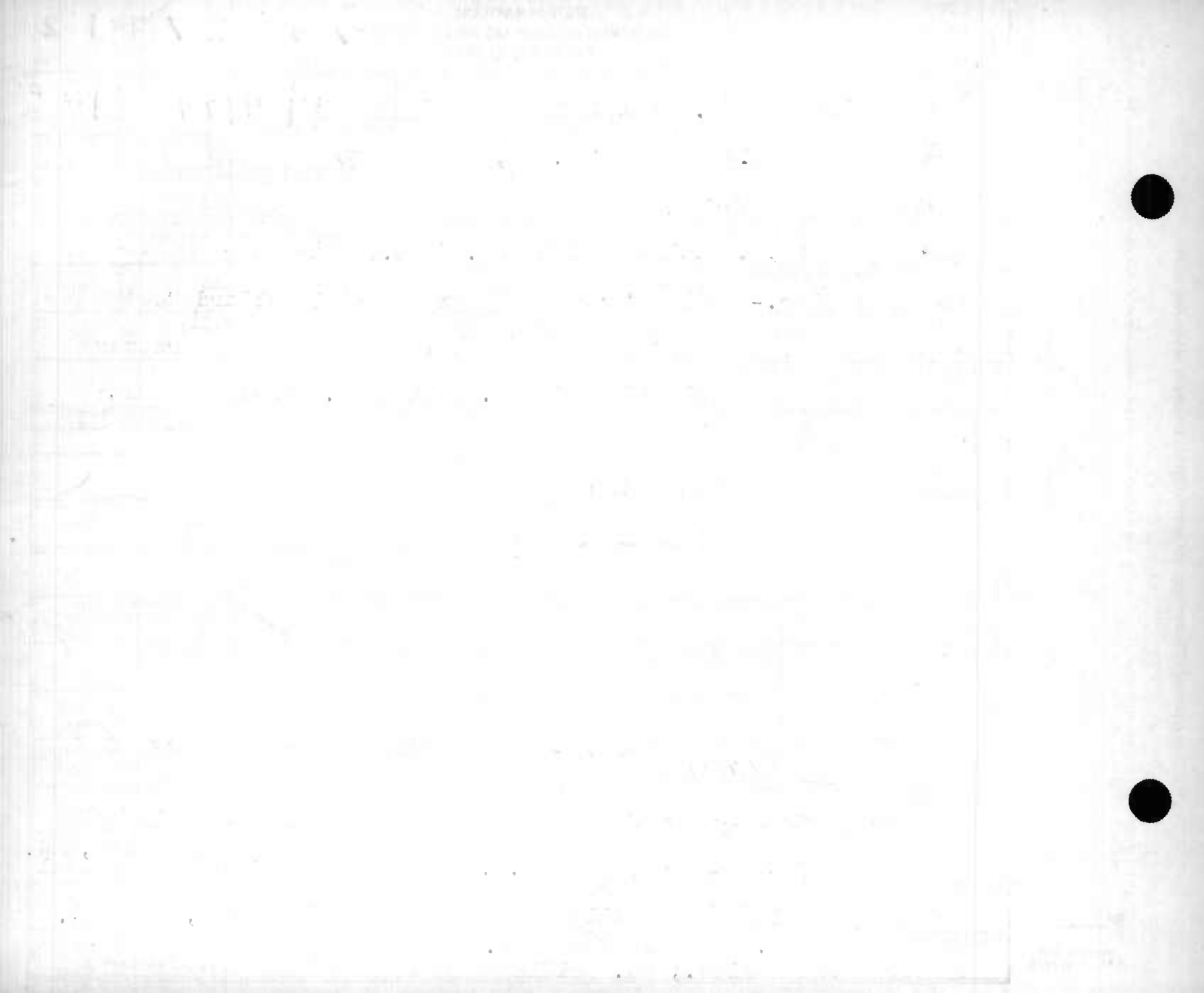
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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Helen M. BASKEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 4 79</b>		2b. HOUR MIN <b>118 P M</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24, 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>71</b>			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>U.S. Public Health Ser. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleswoman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hutzlers</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Middle River</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>John</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julie</b>			16 STREET ADDRESS <b>6707 Mallard Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218 09 5822</b>		17. INFORMANT ADDRESS <b>Mr. William H. Baskey</b>			17b. SAME <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Respiratory Dist</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Dist</b> (c) <b>Small Cell Car Lung</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/12</b> , 19 <b>79</b> , to <b>11/4</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/4/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Rose Fitchett M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/4/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rose Fitchett M.D.</b>				22e. ADDRESS <b>Balto, Md. U.S. Public Health Service Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Middle River, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>				25a. DATE REC'D. BY REGISTRAR <b>UV 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Rose Fitchett</b>			
24b. ADDRESS <b>4905 York Road Balto., Md. 21212</b>									

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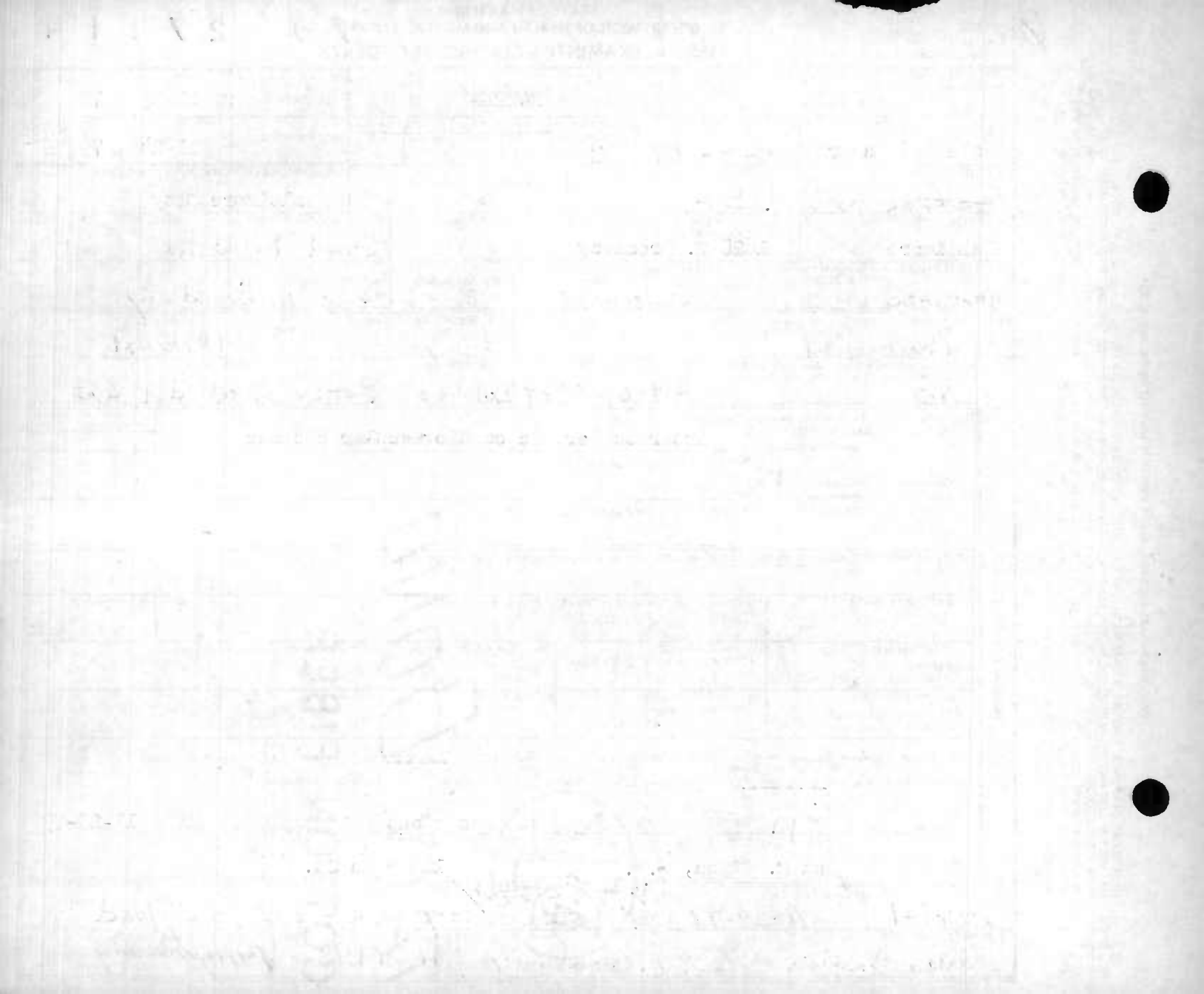
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27114	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>JESSE BATTLE</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11 23 19 79		2b. HOUR M	
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 8-8-07		6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 11 24 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fayetteville N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1628 N. Broadway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) Retired Steel Worker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1628 N. Broadway			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-01-8969		17. INFORMANT Delores Battle				ADDRESS 2000 Odell Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 11-25-79			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-29-79		23c. NAME OF CEMETERY Mt. Olivet Cemetery		23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME William J. Spier				ADDRESS 1637 N. Broadway		25a. DATE REC'D. BY REGISTRAR NOV 27 1979		25b. REGISTRAR'S SIGNATURE <i>F. J. McElroy</i>			





FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

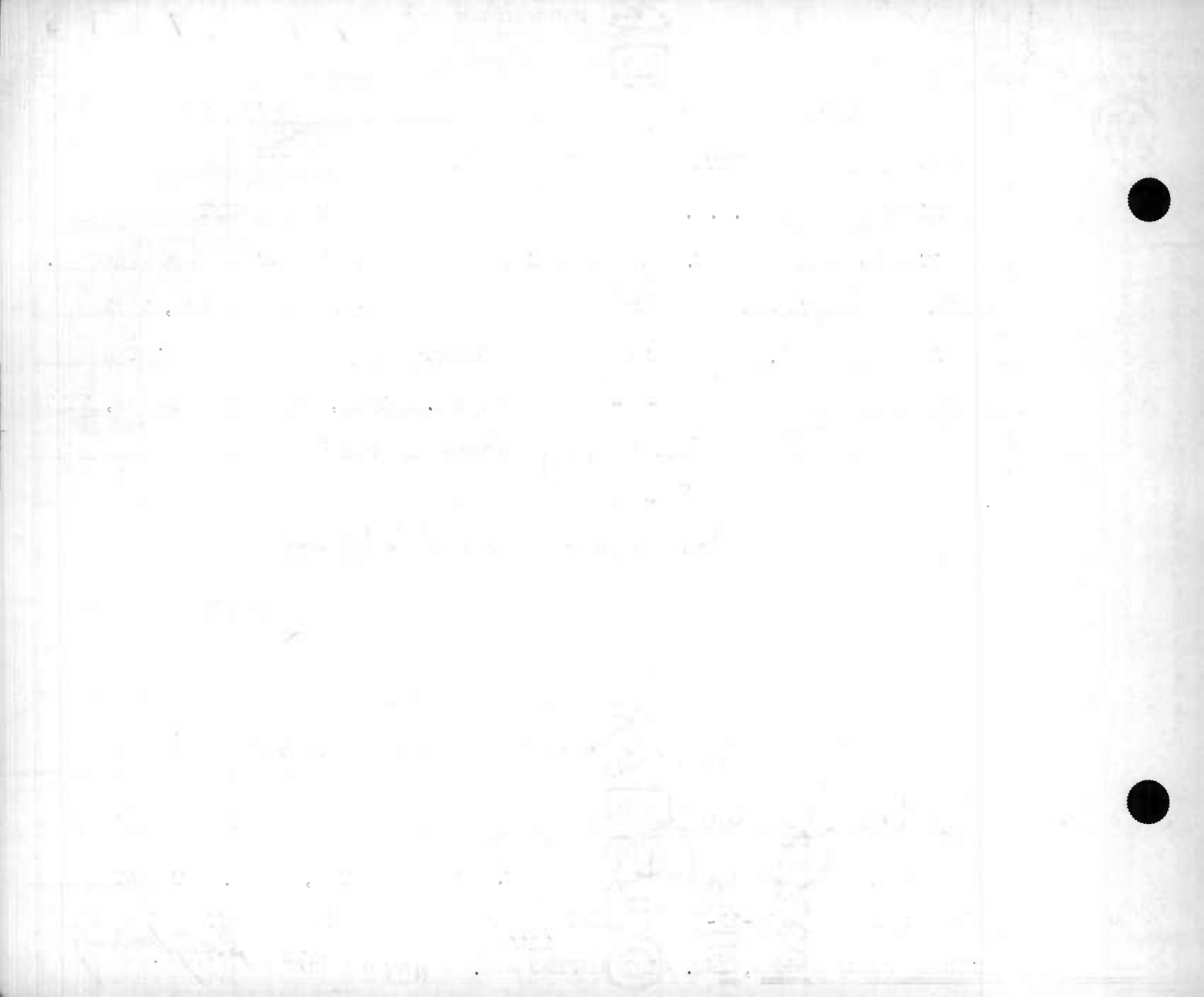
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
HENRY FREDERICK BATZER			11 20 79			240 a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
MALE	WHITE	07 09 1900	79 YRS.			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	U.S.A.				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	ST. AGNES HOSPITAL			MACHINIST			KOPPERS CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. STREET ADDRESS		
MARYLAND			BALTIMORE			94 OAKLEE VILLAGE, 21229		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
JOHN F. BATZER			AUGUSTA BEYER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			212-09-8590			ADELINE E. BATZER, 94 OAKLEE VILLAGE, 21229		
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Waldenström's Macroglobulinemia</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> , 19 <u>79</u> , to <u>11/20</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Patrick W. White</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>11/20/79</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Patrick W. White</u>						22e. ADDRESS ST. AGNES HOSPITAL, 900 S. CATON AVENUE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
ENTOMBMENT			11-23-79		LOUDON PARK		BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR		
HUBBARD FUNERAL HOME, INC.			4107 WILKENS AVE.			NOV 21 1979		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE / 9  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
CORA		LEE		BEASLEY		NOVEMBER 1, 1979		7:30A							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2b. HOUR			
Female		Negro		11 23 1895		83		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		U. S. A.				BALTIMORE CITY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		THE JOHNS HOPKINS HOSPITAL													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland				Baltimore				633 North Aisquith St.							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17. INFORMANT ADDRESS											
				Judy Anderson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS											
				Joseph Beasley 3122 Windsor Avenue											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> <u>4392</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>ASCVD</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER CERTAIN CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
<u>Chronic hypoxia</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>10/29</u> , 19 <u>79</u> , to <u>11/1</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/1</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>JB Leckowith</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>11/1/79</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
<u>JB Leckowith MD</u>		<u>Johns Hopkins Hosp Balt City</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial		11/5/79		Arbutus Mem. Park		Arbutus, Maryland									
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm. C. March F/H 1101 East North Ave.		NOV 2 1979		<u>Johns Hopkins</u>											

24. FUNERAL NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

230. REGISTRAR'S SIGNATURE

1992

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MILTON Edgar BEATTY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 19 1979</b>			2b. HOUR <b>1125 A M</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 29 11</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tester</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bendix</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7711 Wilson Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Edward Beatty</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Horseman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-07-8054</b>		17. INFORMANT ADDRESS <b>Darlene P. Beatty 7711 Wilson Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>5570</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Hyperkalemia</b> (c) <b>Bowel infarction Post op</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION <b>11/15/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT <input type="checkbox"/> UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 16 19 1979</b> , to <b>NOVEMBER 19 19 1979</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 19 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>H Russell Wright MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>11/19/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. Russell Wright</b>				22e. ADDRESS <b>Union Memorial Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>				ADDRESS <b>7401 Belair Road</b>		25a. DATE RECEIVED BY REGISTRAR <b>NOV 23 1979</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages must be notified of once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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ATTACH

NOTES

WITNESS

WITNESS

WITNESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

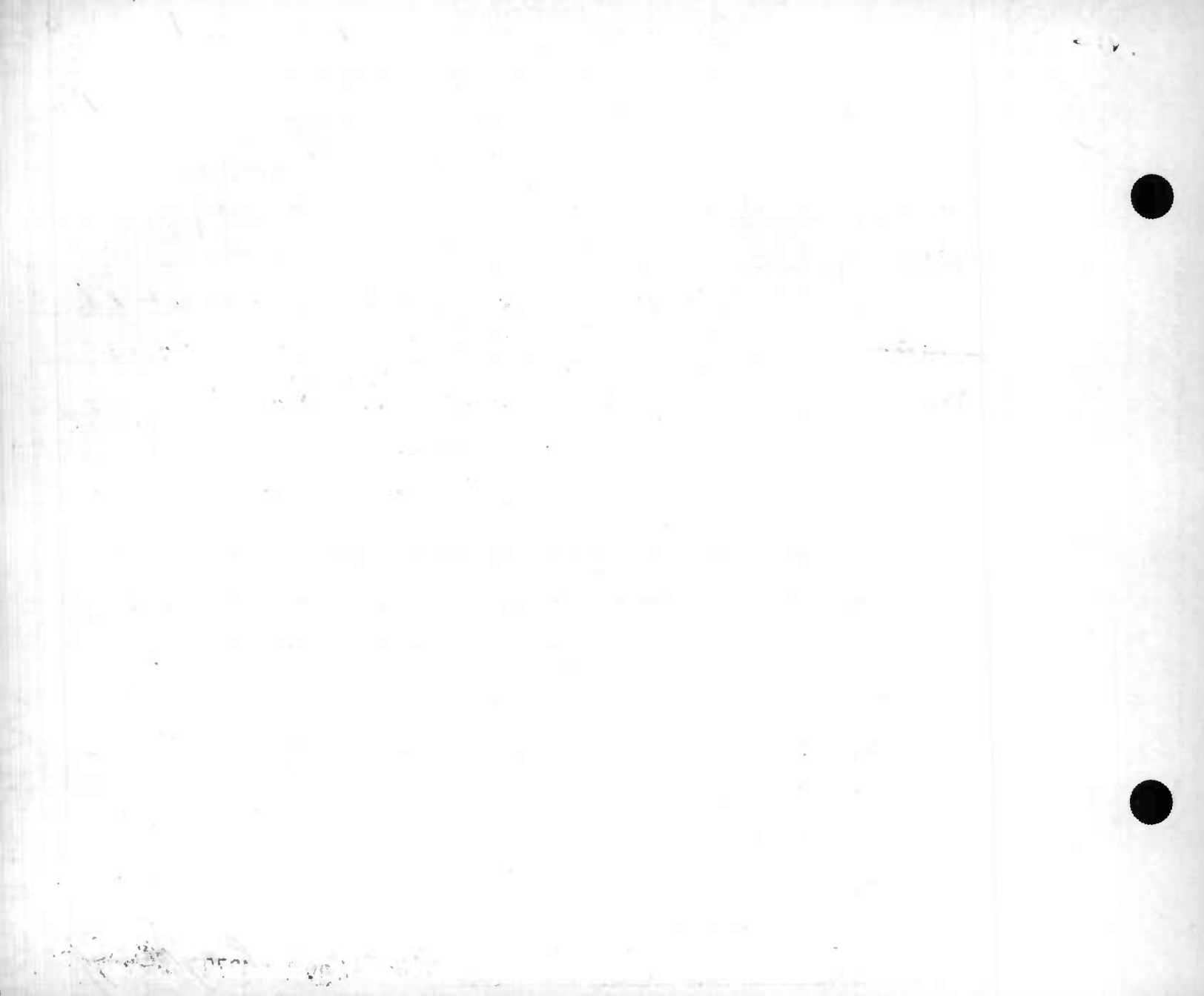
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 2 7 1 1 8		
FOR 1- STATE REGISTRAR			REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <i>IDA</i>			FIRST <i>Becker</i>		LAST		
2a. DATE OF DEATH			MONTH <i>11</i> DAY <i>11</i> YEAR <i>79</i>		2b. HOUR <i>4<sup>00</sup></i> AM		
3 SEX <i>Female</i>		4 RACE <i>W HITE</i>		5 DATE OF BIRTH <i>15</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>74</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Balto City</i> MD.	
10 CITY OR TOWN OF DEATH <i>Balto. city</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hebrew Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <i>MD</i>		13b. CITY OR TOWN <i>Balto.</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME <i>Issac</i>		15. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>XXXXXX</i>	
17 INFORMANT <i>DANIEL BECKER</i>		17a. ADDRESS <i>2937 MARNAT RD. #21209</i>		17b. CITY OR TOWN <i>BALTIMORE</i>		17c. STATE <i>MD</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Atherosclerosis</i> (c) <i>years</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10-15 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED <i>11/11/79</i>	
22a. I certify that this hospital attended the deceased from <i>10/15</i> 19 <i>76</i> to <i>11/11</i> 19 <i>79</i> , that (we) last saw the deceased alive on <i>11/11</i> 19 <i>79</i> and that in our opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) see the body after death.						22b. SIGNATURE <i>[Signature]</i> DEGREE	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NOEL D. LIST</i>						22d. ADDRESS <i>2434 W BELVEDER (21215)</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>NOV. 12, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SHAAREI TFILOH</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i>	
24 FUNERAL DIRECTOR NAME <i>SOL LEVINSON &amp; BROS., INC.</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 14 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
6010 REISTERSTOWN RD. BALTO, MD 21215							

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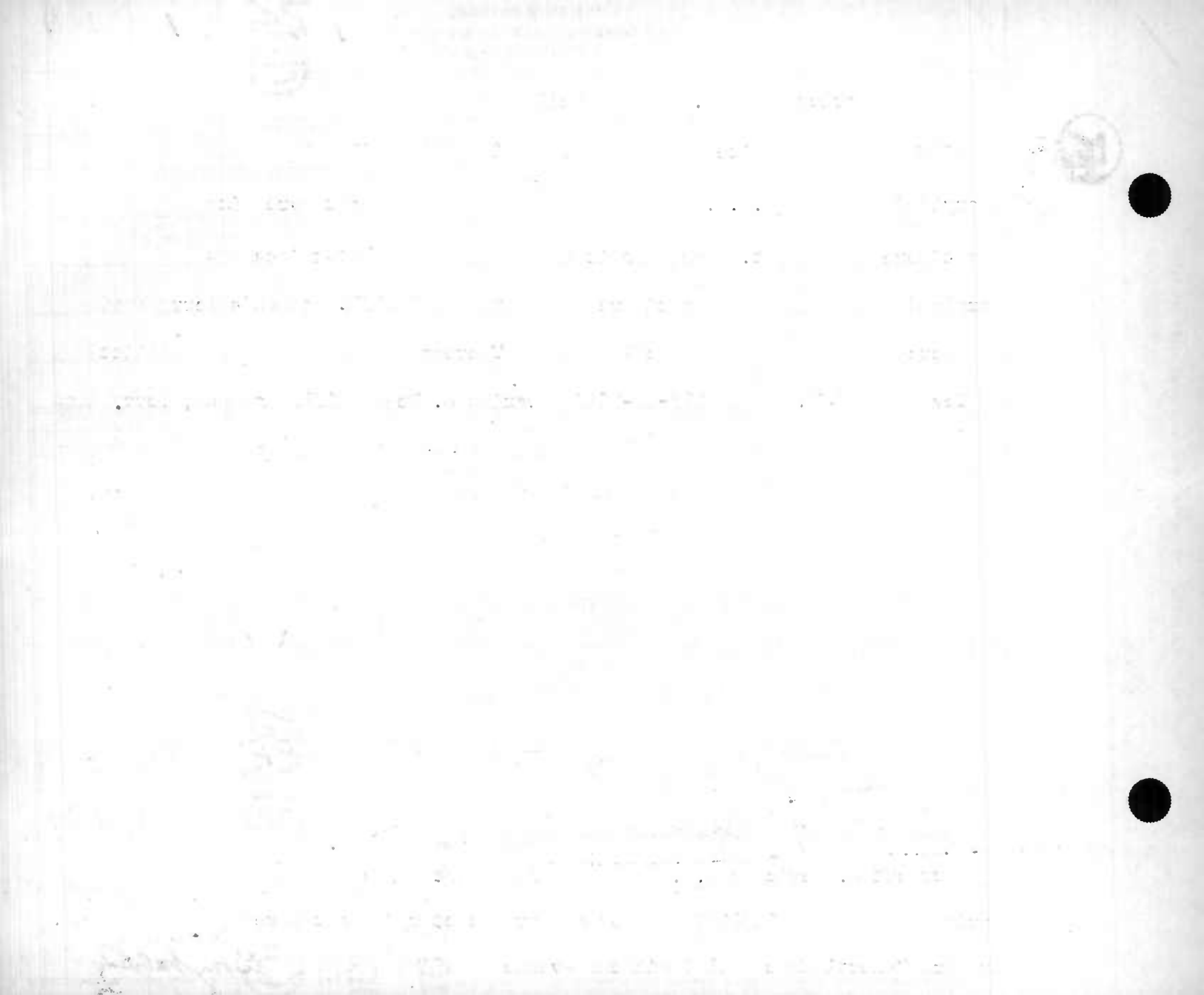


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 1 1 9				
1- FOR STATE REGISTRAR		REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Charles		A.				Bell		11		8	79	9:09 P.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		MONTH 4 DAY 2 YEAR 18		61		MONTHS		DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		U.S.A.				Baltimore City						MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore		St. Agnes Hospital		Maintenance Man										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		BALTO		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2515 Hammonds Ferry Road						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST		FIRST MIDDLE LAST												
Percy		Bell		Theresa		Plitt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
Yes		WWII		215-09-2245		Marian L. Bell		2515 Hammonds Ferry Road						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute MI</u> (c) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sublethal</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> 19 <u>68</u> to <u>11/8</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED						
Herbert J. Levickas		MD						11/8/79						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
Herbert J. Levickas M.D.		5404 East Drive												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial		11/12/79		Loudon Park Cemetery		Baltimore						Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Hubbard Funeral Home		4107 Wilkens Avenue		NOV 13 1979		R. J. Halvick								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

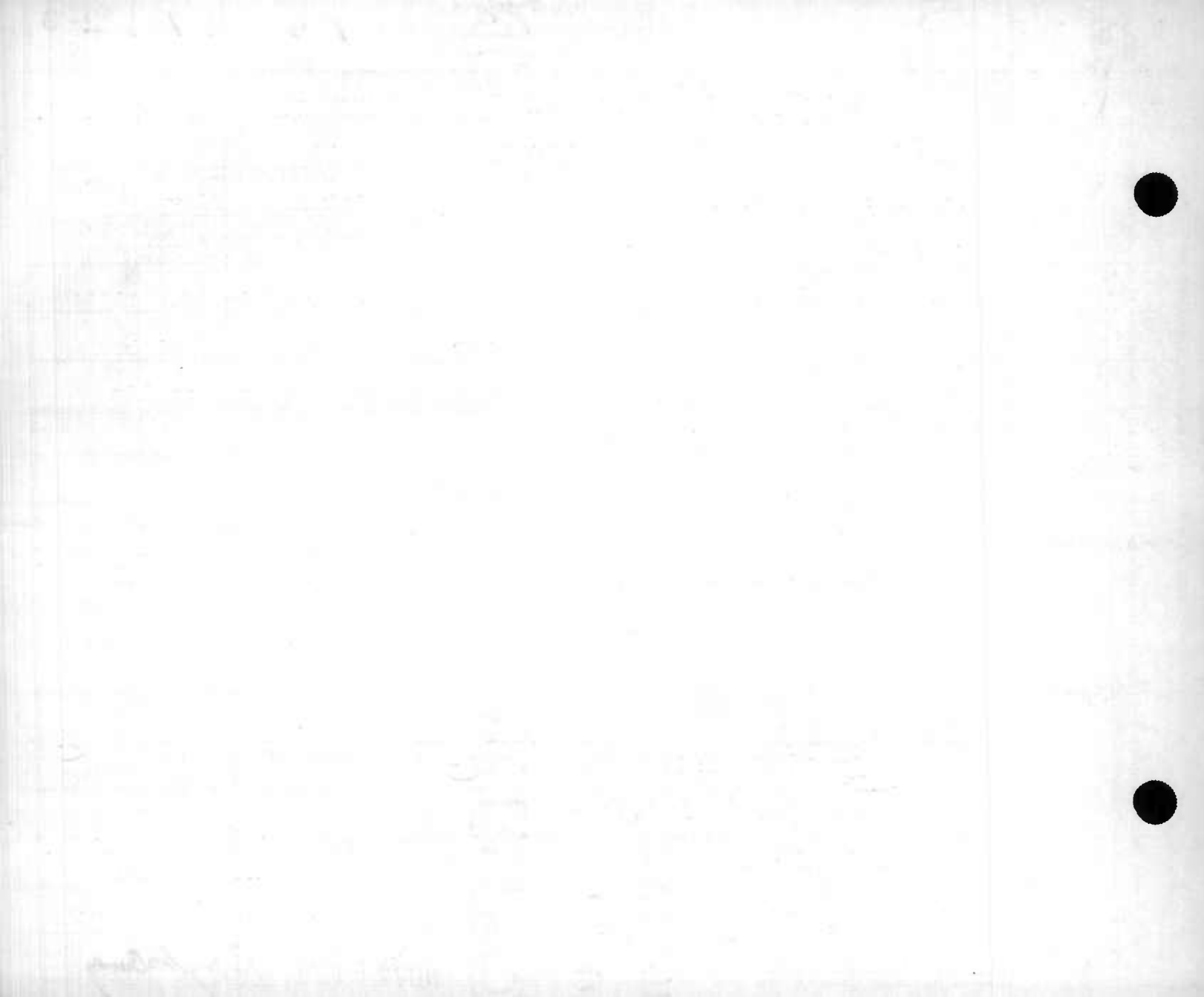
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 7 9 2 7 1 2 0									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARGARET		MIDDLE PATRICIA		LAST BELT		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
								NOVEMBER 18 1979		6:15A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		5/27/1900		79 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Church Hospital, Inc.						HOUSEWIFE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Balto.		Dundalk				24 Township Rd. 21222			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Henry Pietroff				Anne Holshou							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No				214.14.5855		Robert F. Belt----Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4415 CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURED AORTIC ANEURYSM											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) M MYOCARDIAL ISCHEMIA, ARTERIOSCLEROTIC CARDIOVASCULAR HEART DISEASE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
NOVEMBER 18, 1979		RUPTURED ANEURYSM				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 14, 19 79, to NOVEMBER 18, 19 79, that (I) (we) lost saw the deceased alive on NOVEMBER 18, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Sompalli Prasad DEGREE								22c. DATE SIGNED			
								NOVEMBER 18, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOMPALLI PRASAD						22e. ADDRESS CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		11/21/1979		Oak Lawn Cemetery		Baltimore Md.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Walter Brooks Bradley Inc. Dundalk Md						NOV 20 1979		[Signature]			

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TO HOSPITALS, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						7 9 2 7 1 2 1			
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) WILBUR G BELT			2a. DATE OF DEATH MONTH DAY YEAR 11 17 79			2b. HOUR 12 50 P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR May 26, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lithographer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST late Arthur G. Belt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Edna E. Belt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 213 01 4725		17. INFORMANT ADDRESS Mrs Mary B. Belt 5627 Harpers Farm Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas Sepsis</u> 496- DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen Plantholt</u>			DEGREE			22c. DATE SIGNED 11/17/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN PLANTHOLT			22e. ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 19, 1979		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Harry H. Witzke			ADDRESS 4114 Columbia Rd Ellicott Cty			25a. DATE REC'D. BY REGISTRAR NOV 23 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



BALTIMORE CITY

BALTIMORE ST. AGNES HOSPITAL

Info. re. info

500 CATON AVE. BALTIMORE, MD. 21220

WALTON ROAD, BALTIMORE, MD. 21220

WALTON ROAD, BALTIMORE, MD. 21220

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

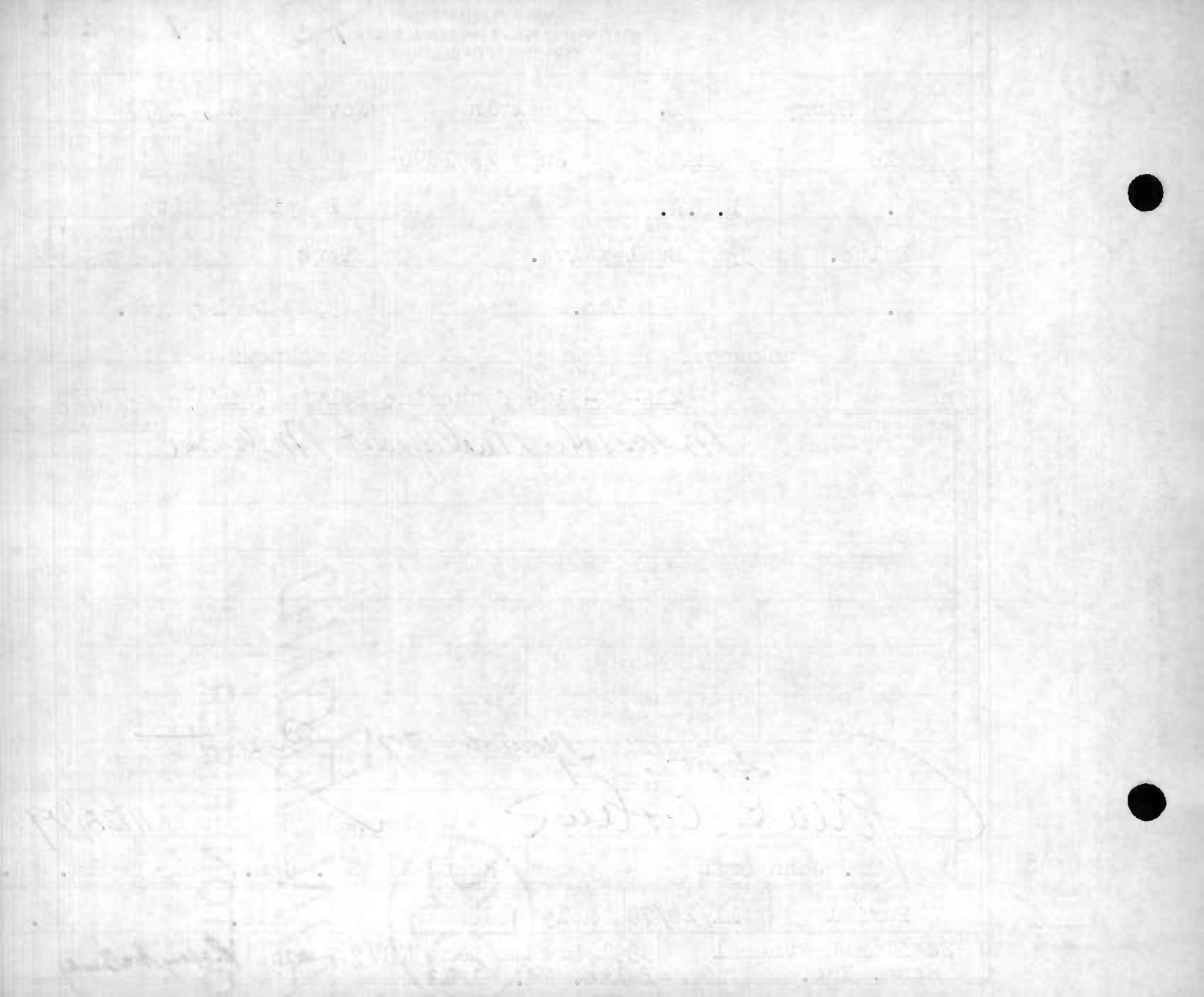
1 DECEASED NAME (TYPE OR PRINT) Harry B. Belvin			2a DATE OF DEATH MONTH DAY YEAR November 24, 1979			2b HOUR M				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 20 1896		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10 CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3329 Dudley Ave.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b KIND OF BUSINESS OR INDUSTRY Car Loading		
13a STATE Md.			13b COUNTY		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 3329 Dudley Ave.	
14 FATHER'S NAME FIRST MIDDLE LAST unknown			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO 214-05-3168		17 INFORMANT Katherine Belvin (wife) address same					
18 CAUSE OF DEATH Enter only one cause on line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Malignant Melanoma</u> 1729 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 77</u> to <u>Present</u> 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>Sept 77</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>John E. Orth</u>			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 11/28/79		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John Orth			22g. ADDRESS Rosedale Med. Cen., 8019 Phila. Rd.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/28/79		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24 FUNERAL DIRECTOR Schimunek Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR NOV 27 1979			25b. REGISTRAR'S SIGNATURE <u>Anthony A. Brady</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





RELEASED BY MEDICAL EXAMINER'S OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Grace		MIDDLE L.		LAST Benefield		26. DATE OF DEATH	
GRACE		BENEFIELD		MONTH 10 DAY 16 YEAR 72		2b HOUR 12:52 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
				MONTH 10 DAY 12 YEAR 12		67 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		U.S.A.				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO		Baltimore City Hospitals				Operator		Four Roses	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7214 Birch Avenue	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
Jerry Bevan				Catherine Decker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				220-14-9298		Shirley Matthys		7214 Birch Ave. Balto. MD 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) UNKNOWN									
7999 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
ASCVD; CHF									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 16 Nov 1979, to 16 Nov 1979, that (we) last saw the deceased alive on 16 Nov 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
THOMAS ABRONZO MD								16 Nov 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
THOMAS ABRONZO		JOHNS HOPKINS HOSP							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY	
Burial		11/20/79		Oak Lawn		Baltimore, Baltimore, MD			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME Duda-Ruck, Inc.		NOV 21 1979				[Signature]			
ADDRESS 7922 Wise Avenue, Dundalk, MD 21222									

BP

RECEIVED

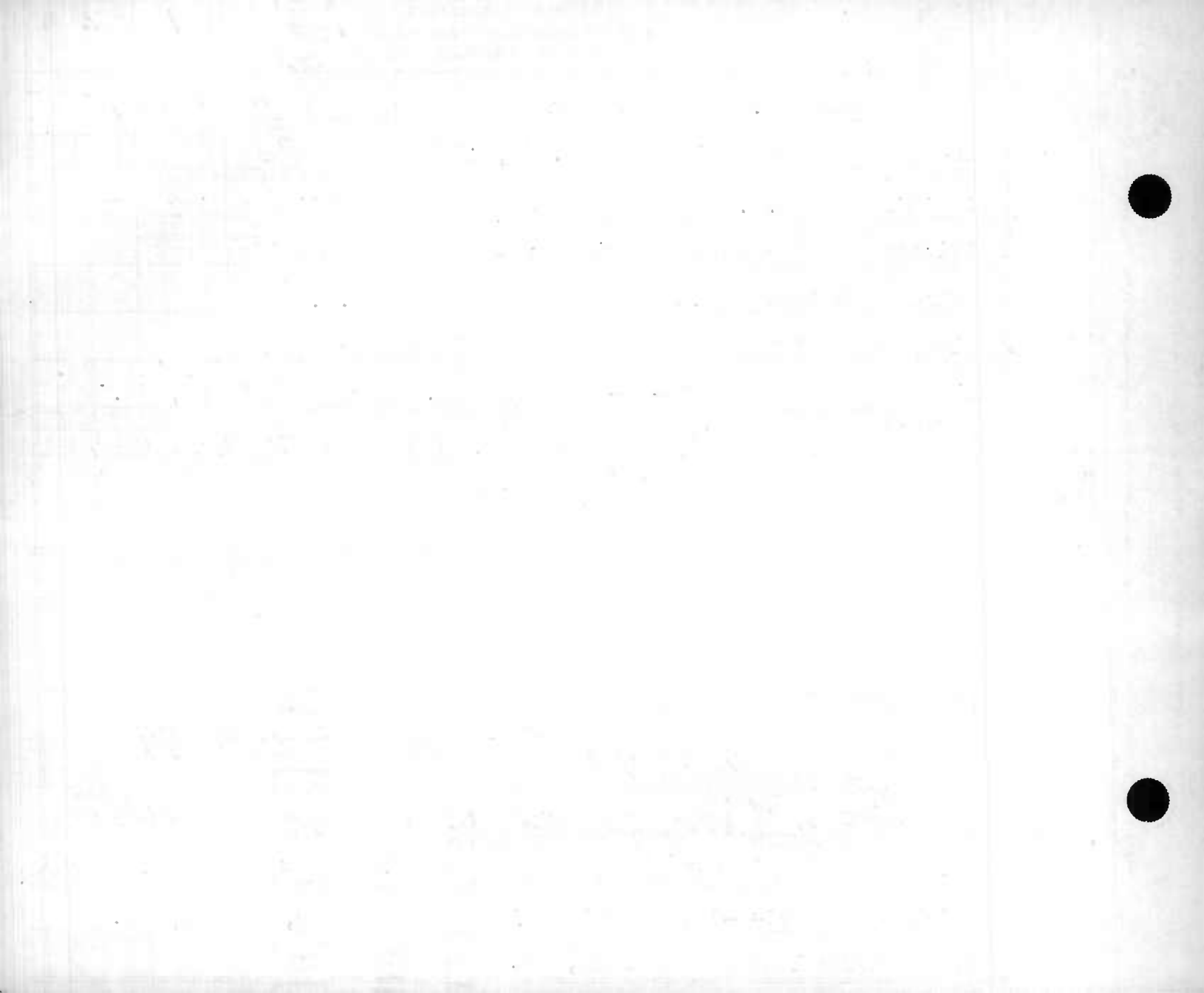
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 1 2 4 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) GRACE W. BENNETT				2a. DATE OF DEATH MONTH DAY YEAR 11-2-79				2b. HOUR 2:45 P.M.			
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 12, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edgewood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. #5	
14. FATHER'S NAME FIRST MIDDLE LAST Alpha Lee Walker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lorena Ashburn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-05-7628		17. INFORMANT ADDRESS Edgehill Ave. Alpha L. Peery Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia Angina										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-3 YRS-	
4148 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) H-A SCLD-											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/2/79 3/13/78, to 11/2/79 11/2/79, that (I) (we) last saw the deceased alive on 11/2/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE Anthony F. Carozza MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/2/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anthony F. Carozza				22e. ADDRESS 6000 Bellona Ave Balt Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-6-1979		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Easton, Talbot, Md.			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.				25a. DATE REC'D. BY REGISTRAR NOV 06 1979		25b. REGISTRAR'S SIGNATURE [Signature]	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IT MUST BE EXECUTED WITHIN 72 HOURS. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27125																																																	
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH										2b. HOUR																																																	
Marshall R. Benton																				11 20 19 79										AM																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										IF UNDER 1 YR.										IF UNDER 24 HRS.										2c. DATE PRONOUNCED DEAD										2d. HOUR									
male										black										3/15/59										20 YRS.																														11 20 19 79										4:25 AM									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										NEVER MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH																																							
Md.										U.S.A.										WIDOWED										DIVORCED										Baltimore City										MD.																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Baltimore										University Hospital (MIEM)										Student										College																																																	
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																																							
Md										City A.A.										Balto.										YES										23 Cedar Hill Lane																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																													
Garrison										Spencer										Edith										Spencer																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1 DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
8230										Multiple injuries with complications																																																																					
																				(b)										DUE TO, OR AS A CONSEQUENCE OF																																																	
																				(c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																											
																				YES										NO																																																	
21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																											
UNDERLYING CONTRIBUTING OR CAUSE OF DEATH										12:18 PM 11/6/79										driver of auto in collision with fixed objects																																																											
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																																																											
WHILE AT WORK NOT WHILE AT WORK										shopping lot										SouthviewShopLot&MorganRd,										AA co., MD																																																	
22a. I certify that I took charge of the remains described above, held an										Autopsy										Inspection										Inquiry										and in my opinion																																							
death resulted from										Natural causes										Accident										Suicide										Homicide										Undetermined manner																													
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																											
Hormez R. Guard, MD.										Assistant										11/20/79																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																																					
12a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																																																	
Burial										11/24/79										Cedar Hill Cem.										Brooklyn										Md.																																							
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. SIGNATURE																																																											
NAME										ADDRESS										NOV 27 1979																																																											
Charles A. Rice										1300 Eutaw Place																																																																					

MEDICAL CERTIFICATION

THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES  
DEPARTMENT OF CHEMISTRY

TO: Mr. J. H. Duerksen  
FROM: Mr. J. H. Duerksen  
SUBJECT: [illegible]

RE: [illegible]  
[illegible]

Enclosed for you are [illegible]  
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Very truly yours,  
J. H. Duerksen  
J. H. Duerksen



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 2 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELSIE</b> <b>BERGER</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>11</b> YEAR <b>79</b>		2b. HOUR <b>6:45 AM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>23</b> YEAR <b>15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD. Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.			10. CITY OR TOWN OF DEATH <b>BALTIMORE City</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH CHARLES HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>APT. E-5 #21215</b> <b>GUENQYLE Ave.</b>
14. FATHER'S NAME FIRST <b>LOUIS</b> MIDDLE <b>COPELAND</b> LAST <b>COPELAND</b>			15. MOTHER'S MAIDEN NAME FIRST <b>DINAH</b> MIDDLE <b>LEVIN</b> LAST <b>LEVIN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213054520</b>		17. INFORMANT <b>APT. E-5 ADDRESS #21215</b> <b>Joseph BERGER 3635 Guenqyle Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA BREAST WITH METASTASIS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10-31-1979</b> , to <b>11-11-1979</b> , that (I) (we) lost saw the deceased alive on <b>11-11-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Varughese Kuruvilla</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-11-1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VARUGHESE KURUVILLA</b>		22e. ADDRESS <b>NORTH CHARLES GENERAL HOSPITAL, BALTIMORE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>NOV. 12, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOSES MONTEFIORE</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert H. Brandy</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



Handwritten signature or initials in the bottom left corner.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		7 9 2 7 1 2 7		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ROSALIE</b> <b>BERLIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 14 1979</b>		2b. HOUR <b>1:37 P.M.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 24, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY - BALTIMORE</b> MD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>			10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13b. STREET ADDRESS <b>8219 MARCIE DR. 21208</b>			13c. CITY OR TOWN <b>BALTO</b>		
13d. STATE <b>MD</b>			13e. COUNTY <b>BALTIMORE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>BARNEY LIPSITZ</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DORA ROSEN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>220-14-3411</b>		
17. INFORMANT <b>SAMUEL BERLIN</b>			18. ADDRESS <b>8219 MARCIE DR. BALTO., MD 21208</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. <b>metastatic breast carcinoma</b> IMMEDIATE CAUSE (a) <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&gt; 1 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/4</b> to <b>11/14</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Gorend P. Lichtenfeld MD</b>		22c. ADDRESS <b>2435 W. Belvedere Ave.</b>		22d. DATE SIGNED <b>11/14/79</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gorend P. Lichtenfeld MD</b>		22f. ADDRESS <b>2435 W. Belvedere Ave.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>NOV. 16, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAT ISRAEL (MISHKON ISRAEL SEC.)</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>R. H. H. H.</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

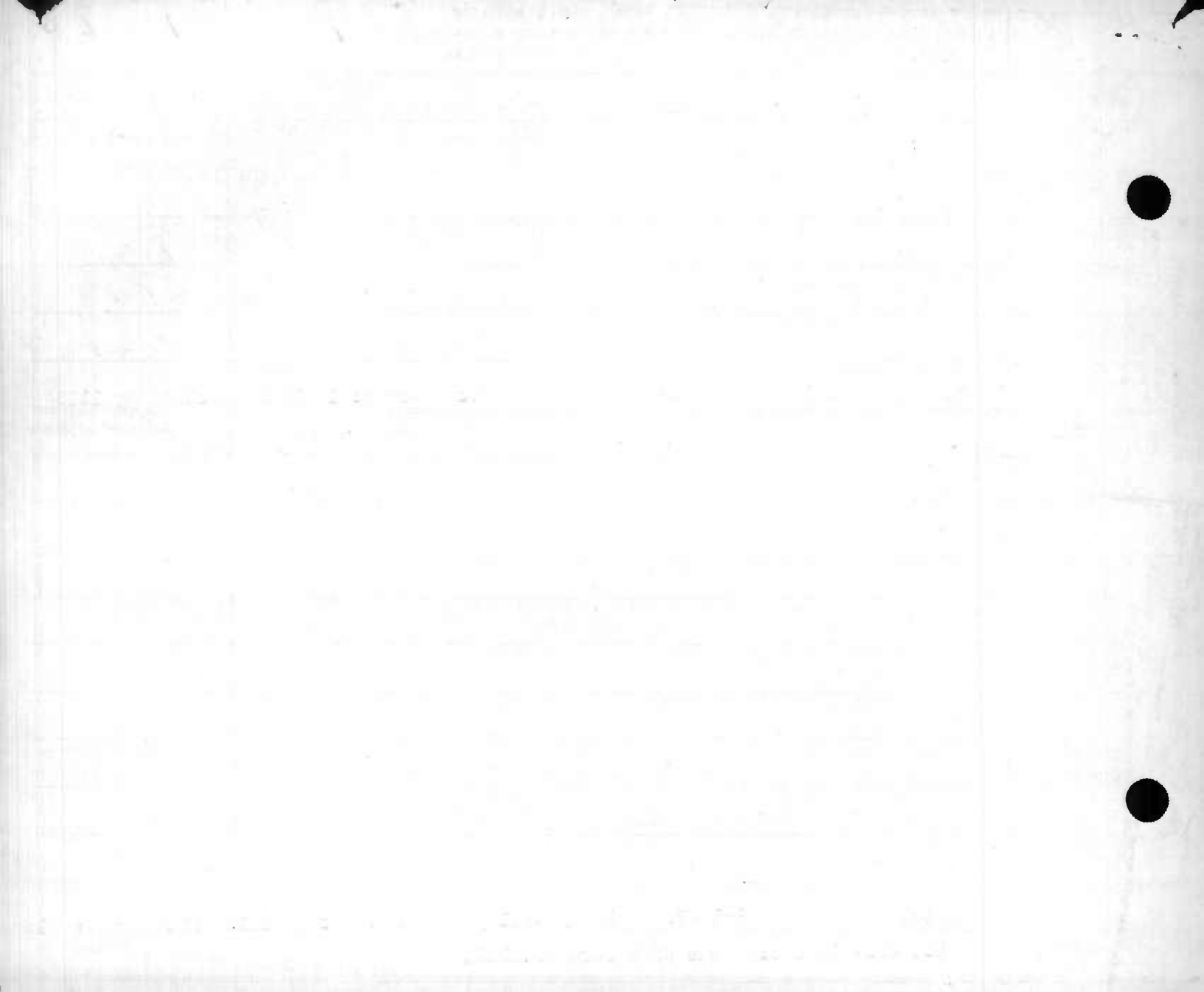
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1. STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maurice Jack Bernstein					2a. DATE OF DEATH MONTH DAY YEAR 11 13 79 2b. HOUR 6:10 P.M.					
3. SEX M		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 1 26 11		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shoe buyer		12b. KIND OF BUSINESS OR INDUSTRY Retail		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2303 Pentland Dr	
14. FATHER'S NAME FIRST MIDDLE LAST Jack Bernstein					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Schwartz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>			16b. SOCIAL SECURITY NO 34440 6280		17. INFORMANT ADDRESS Margaret D Bernstein 2303 Pentland dr 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Myelocytic Leukemia 2050 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonitis, diffuse										
19a. DATE OF OPERATION 11/6/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumonitis				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7/6, 19 79, to 11/13, 19 79, that (I) (we) last saw the deceased alive on 11/13, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE MD Steven Fishkoff					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/13/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Fishkoff					22e. ADDRESS MRC 225 Greene St. Baltimore Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-16-79		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Baltimore Maryland				
24. FUNERAL DIRECTOR W Mitchell-Wiedefeld Home 6350 York Rd. 21212					25a. DATE REC'D. BY REGISTRAR NOV 19 1979 25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1- STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Delma Irene Berry</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 7, 1979</b>			2b. HOUR <b>12:40 AM</b>		
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1/2/33</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD				
10. CITY OR TOWN OF DEATH <b>Balto. City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>US Public Health Service Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>					13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. STREET ADDRESS <b>4405 Vesta Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alphonso Bowie</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Edwards</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-26-2334</b>		17 INFORMANT ADDRESS <b>Records- US PHS Hospital</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRCULATORY COLLAPSE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SHOCK LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ESOPHAGEAL CARCINOMA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>#2 TERMINAL</b> <b>ONE WEEK</b> <b>3 MONTHS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION <b>8/28/79, 9/26/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ESOPHAGEAL CARCINOMA</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 24</b> , 19 <b>79</b> , to <b>Nov. 7</b> , 19 <b>79</b> that (I) (we) saw the deceased alive on <b>Nov. 7</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.										
22b. SIGNATURE <b>Drew Dillman, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/7 79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DREW DILLMAN, M.D.</b>						22e. ADDRESS <b>3100 Wyman Pk. Drive</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10 Nov. 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn Pk. Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Powell P/H</b>						24b. ADDRESS <b>319 N. Schroeder St</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1979</b>		

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at the Government Printing Office  
Washington, D.C.

RECORDS OF THE HOUSE

MAINTAINED BY THE HOUSE

OF REPRESENTATIVES

WASHINGTON

1914

Volume 1

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Nathaniel Fred Berry</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>21</b> YEAR <b>79</b>			2b. HOUR <b>M</b>					
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>05</b> DAY <b>10</b> YEAR <b>1885</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2503 Overland Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waiter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2503 Overland Ave.</b>		
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Berry</b> LAST <b>Berry</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Ella</b> MIDDLE <b>Berry</b> LAST <b>Berry</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>231-40-9545</b>	
17. INFORMANT ADDRESS <b>21214</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>possible acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>possible carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>possible carcinoma of lung</u>											
19a. DATE OF OPERATION <b>9/13/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>possible carcinoma of lung</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/13/79</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): <b>possible carcinoma of lung</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>2300 Garrison Blvd. Balto. Md. # 16</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2300 Garrison Blvd. Balto. Md. # 16</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/13/79</b> to <b>11/21/79</b> , that (I) (we) last saw the deceased alive on <b>11/13/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. Elijah Saunders</b>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>11/21/79</b>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Elijah Saunders</b>			22f. ADDRESS <b>2300 Garrison Blvd. Balto. Md. # 16</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-26-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lynchburg Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Herbert E. Nutter</b>			24b. ADDRESS <b>3035 W. North Ave.</b>			24c. DATE REC'D. BY REGISTRAR <b>NOV 26 1979</b>		24d. REGISTRAR'S SIGNATURE <b>John H. Brady</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 1 3 1			
FOR 1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARY M. BERTRAND</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 24, 1979</b>		2b. HOUR <b>7:58 AM</b>	
3 SEX <b>FEMALE</b>	4 RACE <b>CAUCASIAN</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>04 04 27</b>		6 AGE [IN YEARS LAST BIRTHDAY] <b>52</b> YRS.	7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL STORE</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>ARBUTUS</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1209 JUNE RD. (21227)</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOHN WEIDNER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EDNA SAHM</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO <b>217-20-2921</b>		17 INFORMANT ADDRESS <b>ARTHUR G. BERTRAND, 1209 JUNE ROAD, 21227</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2030 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHOPNEUMONIA</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>MULTIPLE MYELOMA</b>							<b>6 MOS.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that on (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE <i>Anthony A. Arz</i>				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/24/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTHONY A. ARZ, M.D.</b>				22e. ADDRESS <b>900 CATON AVE. BALTIMORE, MD. 21229</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-27-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>	
24 FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1979</b>		25b. NAME OF REGISTRAR <i>John J. ...</i>	

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

500 CATON AVE. BALTIMORE, MD. 21206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 7 1 3 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Rachel E. BETHEL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 27, 1979</b>		2b. HOUR <b>7:35 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 6 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR</b> COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>French</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lottie Carter</b>		13e. STREET ADDRESS <b>6804 Richardson Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>251-42-7577</b>		17. INFORMANT ADDRESS <b>Herman Bethel 3322 Elmora Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Ovarian Carcinoma</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 9, 1979</b> , to <b>November 27, 1979</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>November 27, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Eugenio S. Machado</b>				DEGREE <b>M. D.</b>		22c. DATE SIGNED <b>11/27/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eugenio Machado, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/1/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Columbia, South Carolina</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 East North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 29 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara McCreedy</b>	

BP \_\_\_\_\_

Metastatic Ovarian Carcinoma

Integrating Conceptual Analysis

Baltimore City

November 27, 1979

.74

[illegible]

November 27

17

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE / 9 27133  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charlotte Betz</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 14, 1979</b>		2b. HOUR <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 19 1896</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	7. UNDER 1 YEAR MONTHS DAYS
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	8b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1103 S. Baylis St.</b>	12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	13. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13. STREET ADDRESS <b>1103 S. Baylis St.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Benton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Tubb</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-16-3242</b>		17. INFORMANT ADDRESS <b>Lillian Jenkins 1103 S. Baylis St.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4280**

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

DUE TO, OR AS A CONSEQUENCE OF (b) **Congestive heart failure**

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

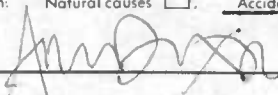

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/21</b> , 19 <b>79</b> , to <b>11/14</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/6</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.			
22b. SIGNATURE <b>Joseph R. Liberto</b> MD	DEGREE <b>MD</b>	22c. DATE SIGNED <b>11/16/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH R. LIBERTO, MD</b>	22e. ADDRESS <b>3508 BARCLAY ST - Baltimore 21224</b>		

23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>Burial</b>	23b. DATE <b>11-17-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>
24. FUNERAL DIRECTOR NAME <b>Thelma A. Hoffmann</b>		25a. DATE REC'D BY REGISTRAR <b>NOV 19 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Thelma A. Hoffmann</b>		25c. REGISTRAR'S ADDRESS <b>3218 Hudson St</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 7 9 2 7 1 3 4			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosa Lee Billings								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11 5 19 79		2b. HOUR M 11:02 A	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 26 1903		6. AGE (IN YEARS) (LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 5 19 79		2d. HOUR A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1502 North Decker Street			
14. FATHER'S NAME FIRST MIDDLE LAST John Sheridan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Frances Brown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 216-10-8513A		17. INFORMANT ADDRESS Deotha Humphrey 3734 Milford Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke Inhalation</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:10 PM 11 5 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject caught in house fire							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1502 N. Decker Ave., Baltimore Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant M.D.				MEDICAL EXAMINER DATE SIGNED 11/6/79					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/10/79		23c. NAME OF CEMETERY OR CREMATORY Maryland Nat. Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 East North Avenue						25a. DATE REC'D. BY REGISTRAR NOV 8 1979		25b. REGISTRAR'S SIGNATURE 					

MEDICAL CERTIFICATION



STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1901.

REPORT

OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 10, 1899.  
ALBANY:  
J. B. LIPPINCOTT & CO., PRINTERS.  
1901.

100

COLL 10724



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9	2 7 1 3 5
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSEPH BIRNBAUM</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11 14 79</b>		2b. HOUR <b>3 17 P M</b>			
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3 25 16</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 YEAR HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TEXAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.					
10 CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Md. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>EXECUTIVE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>TEXAS</b>				13c. CITY OR TOWN <b>SAN ANTONIO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11426 Whisper Green</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>J. I. BIRNBAUM</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE FADEN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>464 12 3596</b>		17. INFORMANT ADDRESS <b>ANNE BIRNBAUM SAME</b>					
18 CAUSE OF DEATH Enter only one cause per part for 10a, 10b, and 10c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> <b>1919</b> Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. (b) <b>Pneumonia</b> (c) <b>Cholelithiasis Multiple</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 1/2 hrs</b> <b>1 yr.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>9-24-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GLIOBLASTOMA MULT.</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <b>9/21</b> 19 <b>79</b> , to <b>11/14</b> 19 <b>79</b> , that <del>we</del> (we) lost saw the deceased alive on <b>11/14/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Michael Salcman</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/14/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL SALCMA</b>				22e. ADDRESS <b>UNIV. OF MD. HOSP., BALTO., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Agudas Achim Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>San Antonio, Texas</b>					
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					
24. ADDRESS <b>4905 York Road Balto., Md. 21212</b>											



10-26-64

EXHIBIT

11-17-64

10-26-64

EXHIBIT

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JENNIE <del>HYDE</del> BISHOP			2a. DATE OF DEATH MONTH DAY YEAR 11 13 79			2b. HOUR 8:59 a.m.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 25, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KESWICK HOME OF INCURABLES				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		
12b. KIND OF BUSINESS OR INDUSTRY None		13a. STATE Maryland						
13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Blackstone Apts. Charles & 33rd Streets		
14. FATHER'S NAME FIRST MIDDLE LAST John Francis Bird Hyde				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Cobb Bird				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-46-0019		17. INFORMANT Son: ADDRESS George W. Bishop, Princeton, New Jersey				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerotic Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 yrs.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>13 Nov 79</u> to <u>13 Nov 79</u> , that (I) (we) lost saw the deceased alive on <u>13 Nov 79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <u>Anthony D. Richardson M.D.</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 13 Nov 1979				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Anthony D. Richardson M.D.</u>				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/16/79		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Balto. Co. Md.		
24. FUNERAL DIRECTOR NAME STEWART & MOWEN CO., 108 W. North Ave. 21201				25a. DATE REC'D. BY REGISTRAR NOV 15 1979		25b. REGISTRAR'S SIGNATURE <u>Patricia McIlwain</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma E. BITZEL			2a. DATE OF DEATH MONTH DAY YEAR 11-7-1979			2b. HOUR 9:12p M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 03 92		6. AGE (IN YEARS LAST BIRTHDAY) 8 7 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fulton Laundry		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md.		13b. COUNTY Catonville		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 711 Academy Rd	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Hudson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Finnick				21228	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-093674		17. INFORMANT ADDRESS Frederick M. Bitzel -67 Garden Ridge Rd.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- Resp. arrest- DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro vascular accident- DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CARCINOMA OF THE COLON, ASCVD, PERIPHERAL VASCULAR DISEASE									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that this hospital attended the deceased from 10-30-1979 to 11-7-1979, that (we) last saw the deceased alive on 11-7-1979, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE Surenindra P. Paruchuri					DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-7-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURENDRA P. PARUCHURI					22e. ADDRESS LUTHERAN HOSP. BAL. MD. 21216				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-10-79		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206					25a. DATE REC'D. BY REGISTRAR NOV 13 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

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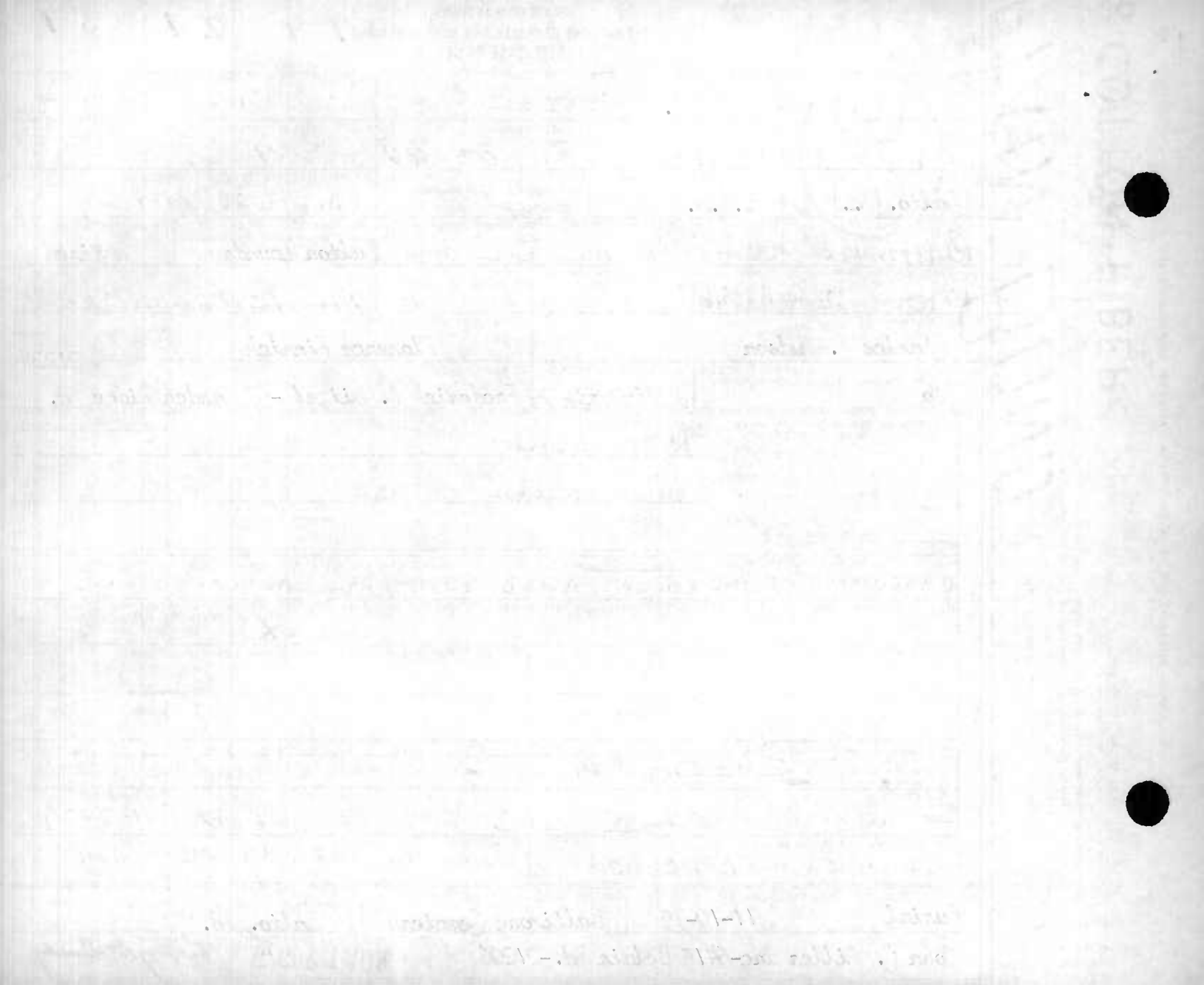
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires: that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			7 9		2 7 1 3 8	
1. DECEASED NAME (TYPE OR PRINT) FRANK R. BIVENS			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 18, 1979		2b. HOUR 3:20 AM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 15, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARMCO STEEL		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY HARFORD	13c. CITY OR TOWN FALLSTON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2102 HARFORD ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST LEONARD BIVENS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA REED				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 207-03-7432		17. INFORMANT ADDRESS FAMILY RECORDS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chordoma of Clivus DUE TO, OR AS A CONSEQUENCE OF (c) Years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (i) this hospital attended the deceased from 10/27/79 to 11/18/79, that (ii) (we) last saw the deceased alive on 11/8/79, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Gary Morgan MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/8/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY MORGAN		22e. ADDRESS Johns Hopkins Hospital, Balt. Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-21-1979	23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEM. C.A.R.		23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR HARFORD MD.	
24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPEL		ADDRESS 8800 HARFORD ROAD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NOV 23 1979		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

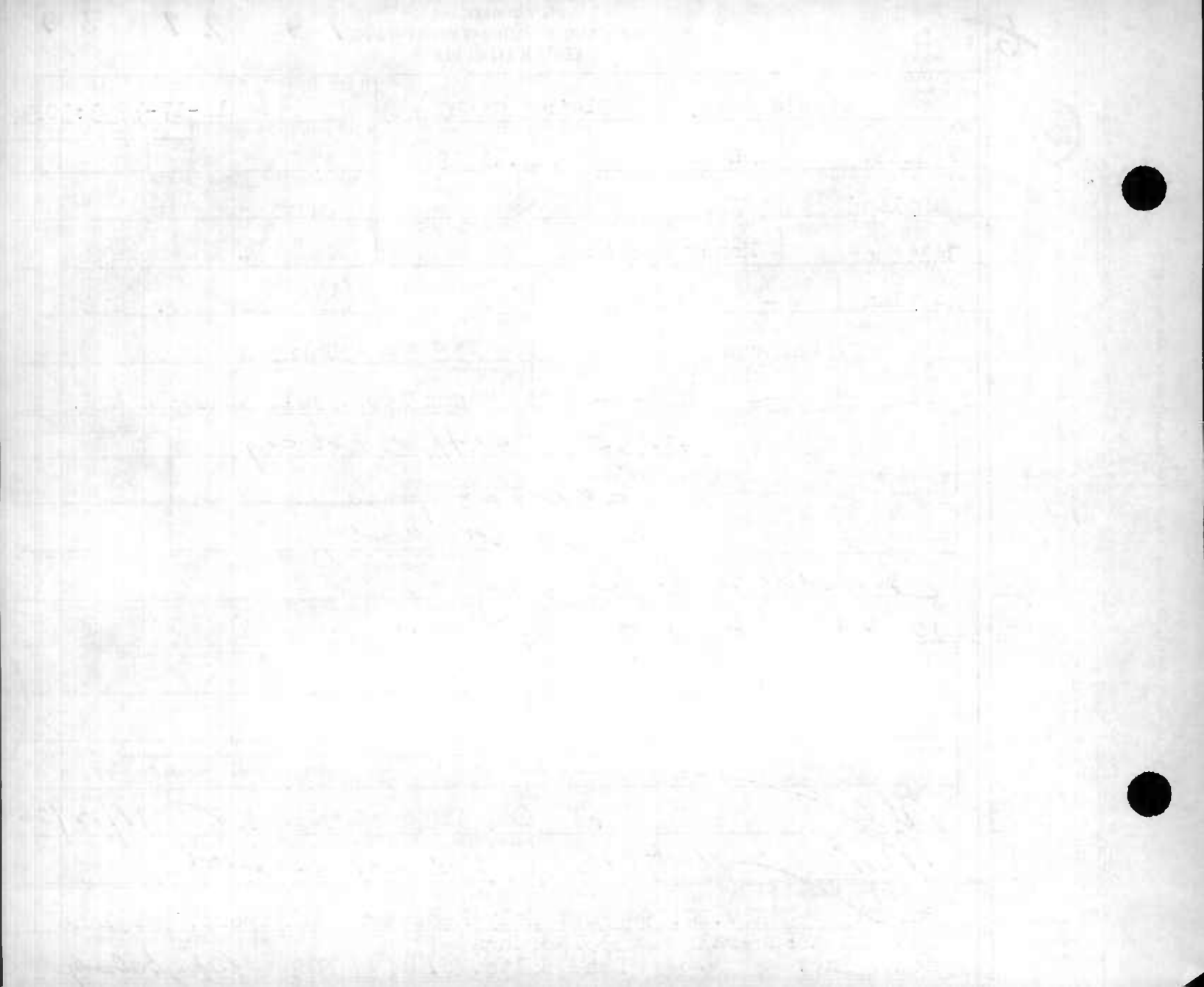
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sophia M. Blair (AKA Blaha)				2a. DATE OF DEATH MONTH DAY YEAR 11-17-79				2b. HOUR 3:30 P.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 31, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. STATE Maryland				13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4149 Marx Ave. 21206			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Anna Petr, 3011 Echodale Ave.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>resp insufficiency</u> 5745 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>renal failure</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>choledocholithiasis to my</u>													
19a. DATE OF OPERATION 10/79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED biliary obstruction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>[Signature]</i>				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/17/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORFESIS				22e. ADDRESS Mercy Hospital									
23a. BURIAL CREMATION REMOVAL (SPECIFY) Burial				23b. DATE Nov. 20, 79		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL HOME OR NAME Schimunek Funeral Home, Inc.				ADDRESS 3331 Brehms Lane, Balto. Md.				25a. DATE REC'D. BY REGISTRAR NOV 20 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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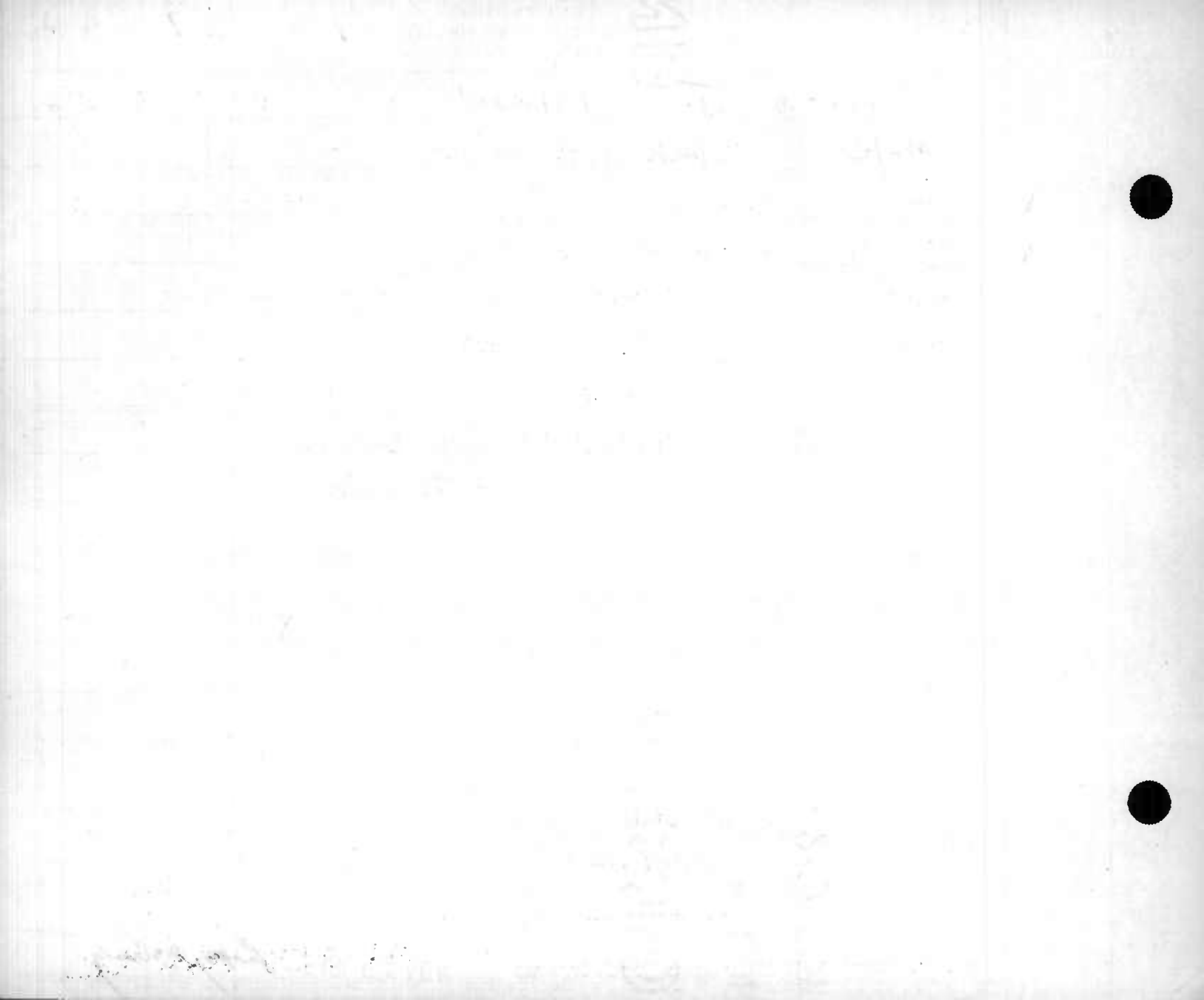


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 1 4 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HAROLD J. BLANDON</b>				2a. DATE OF DEATH MONTH <b>11</b> DAY <b>17</b> YEAR <b>79</b>		2b. HOUR <b>12<sup>45</sup> A M</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>22</b> YEAR <b>1941</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>37</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Junius</b> MIDDLE <b>Blandon</b> LAST <b>Blandon</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ruth</b> MIDDLE <b>Bailey</b> LAST <b>Bailey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-36-2203</b>		17. INFORMANT ADDRESS <b>Janus Blandon 1651 Stonewood Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Liver Disease</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cancer of the Colon</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/26</b> 19 <b>79</b> to <b>11/17</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/17</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>ZAGLAMA</b> MD				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/17/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ZAGLAMA</b>				22e. ADDRESS <b>The Good Samaritan Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/23/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>			
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

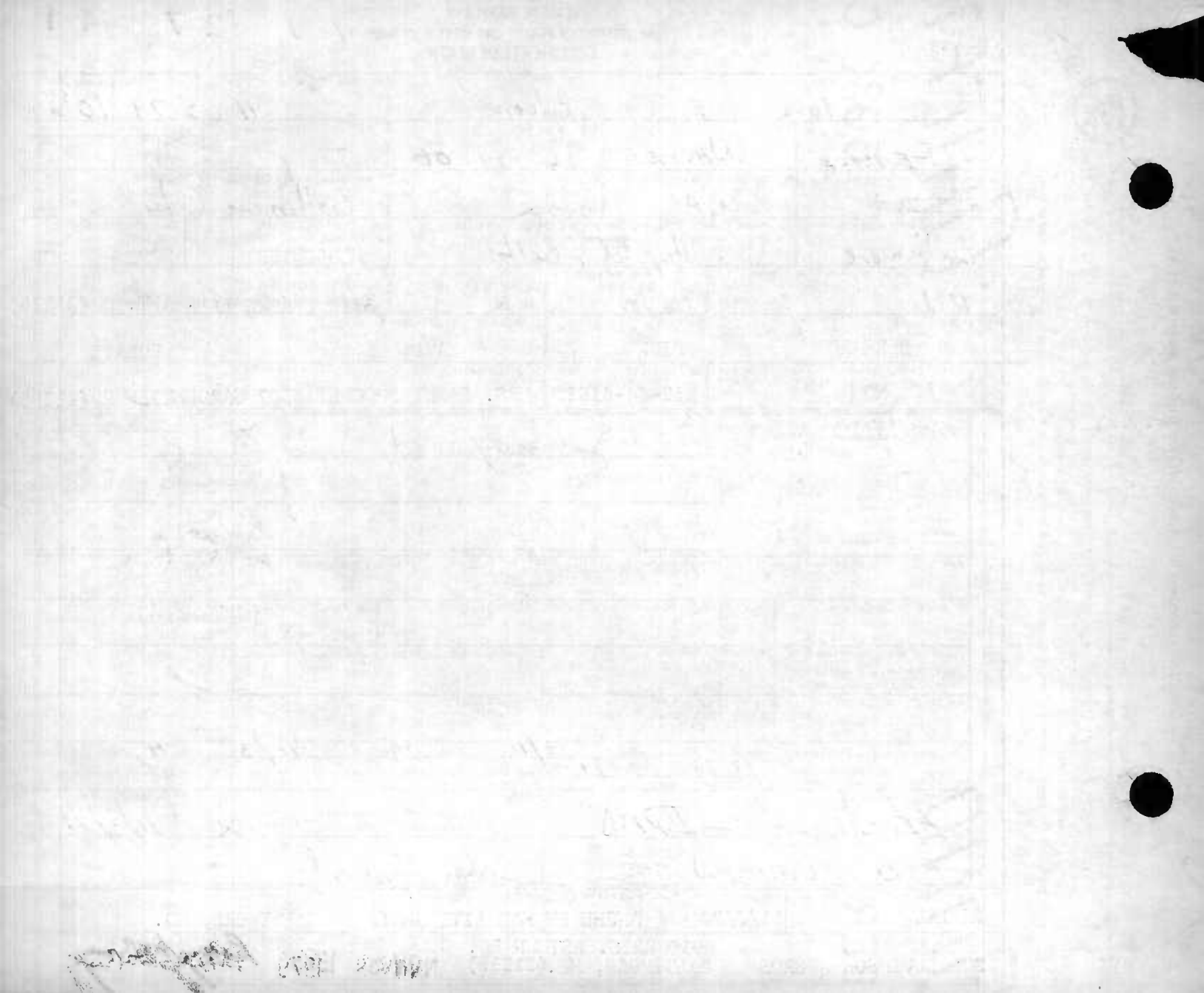
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 4 1

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clara E. Bloom			2a. DATE OF DEATH MONTH DAY YEAR 11 3 79		2b. HOUR 10 <sup>54</sup> M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12 24 06	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital & Balto.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST BERNARD FINK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATE PURATZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-34-4152	17. INFORMANT ADDRESS MRS. SANDY SHOCHET 3507 GARDENVUE RD (21208)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> , 19 <u>79</u> , to <u>11/3</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/3/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE F.B. NEADMAN		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/3/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.B. NEADMAN		22e. ADDRESS Sinai Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 11/5/79	23c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH AITZ CHAIM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS		6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)		25a. DATE REC'D. BY REGISTRAR NOV 8 1979	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be retained by the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 2 7 1 4 2		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM H. BLOUNT</b>			2a. DATE OF DEATH <b>11-2-79</b>		2b. HOUR <b>5:25 PM</b>		
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH <b>OCT. 29, '82</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CRESWELL, N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3214 BURLLEITH AVE.</b>	
14. FATHER'S NAME <b>WILLIS BLOUNT</b>		15. MOTHER'S MAIDEN NAME <b>LAURA HILL BLOUNT</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-01-1406</b>	
17. INFORMANT <b>MRS. LAURA DUNN</b>		18. ADDRESS <b>3214 BURLLEITH AVE.</b>		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> <b>512-</b> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ch. Bronchitis &amp; Asthma &amp; Prost. C.</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>Pneumothorax &amp; Gen. Debilitation</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>13 days</b>		20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. DATE OF OPERATION <b>10.27.79</b>		21a. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Respiratory distress</b>		21b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21g. LOCATION STREET CITY OR TOWN COUNTY STATE	
21h. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21j. LOCATION STREET CITY OR TOWN COUNTY STATE		21k. DATE SIGNED <b>11-2-79</b>	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.		22b. SIGNATURE <b>J. K. Paltheja</b>		22c. DEGREE <b>Attending Physician</b>		22d. DATE SIGNED <b>11-2-79</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. K. Paltheja</b>		22f. ADDRESS <b>Provident Hospital, 2600 Liberty Hts Baltimore</b>		22g. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>		22h. LOCATION CITY OR TOWN COUNTY STATE <b>ARBUTUS, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-7-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARBUTUS, MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT</b> ADDRESS <b>4600 LIBERTY HGS</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. O. Dyett</b>		25c. DATE REC'D. BY REGISTRAR <b>NOV 6 1979</b>	

PAGE-11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page a may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 1 4 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>REBECCA D. BOLLINGER</b>				2a. DATE OF DEATH MONTH <b>11</b> DAY <b>28</b> YEAR <b>79</b>				2b. HOUR <b>1:30</b> P.M.			
3. SEX <b>F</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH <b>Mar.</b> DAY <b>27</b> YEAR <b>1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>4101 Dee Jay Drive</b>			
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>N.</b> LAST <b>Davis</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>B.</b> LAST <b>Eckenrode</b>				ADDRESS <b>4101 Dee Jay Drive</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>217-58-0851</b>		17. INFORMANT <b>Russell Bollinger, Sr.</b>				ADDRESS <b>Ellicott City, Md. 21043</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CAUSE RESPIRATORY ARREST</b> <b>430-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>INCREASED VENTRICULAR PRESSURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SUBARACHNOID HEMORRHAGE 2nd VENTRICULAR ARTERY</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <b>11/22</b> , 19 <b>79</b> , to <b>11/28</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/28</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Edwin H. Bellus</b> DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <b>11/28/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWIN H. BELLUS M.D.</b>								22e. ADDRESS <b>XPT. NEUROSURGERY UNIVERSITY OF MARYLAND HOSPITAL, BALT. MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>				23b. DATE <b>11/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marriottsville, Howard, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>SLACK Funeral Home, Ellicott City, Maryland 21043</b> ADDRESS								25a. DAY RECEIVED BY REGISTRAR <b>DEC 4 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP

11-23-75

Received 14 July 2006; accepted 14 September 2006; first published online 12 October 2006

FACETS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGIANNA Coates</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>15</b> YEAR <b>1979</b>		2b. HOUR <b>6:25 a</b>			
3. SEX <b>female</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>5</b> YEAR <b>1884</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD <b>11 15 1979</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>3311 Egerton Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3311 Egerton Rd.</b>			
14. FATHER'S NAME FIRST <b>David</b> MIDDLE <b>Coates</b> LAST						15. MOTHER'S MAIDEN NAME FIRST <b>Francis</b> MIDDLE <b>Booze</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>220-30-5807</b>		17. INFORMANT ADDRESS <b>Francis Eubanks same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Arteriosclerotic cardiovascular disease</b> <b>4392</b> IMMEDIATE CAUSE (a) <b>4392</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>11/15/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-20-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cem.</b>		23d. LOCATION CITY OR TOWN <b>Balto., Md.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Vernon Bailey F.H.</b> ADDRESS <b>1348 Calhoun St.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 7 1 4 5			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) SOPHIA SOPHIE ROSE BONEY				2a. DATE OF DEATH MONTH DAY YEAR 11-2-79			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 15, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10 CITY OR TOWN OF DEATH BALTIMORE, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITALS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY MAIL BORO SHIRT CO.	
13a. STATE MD.				13b. COUNTY BALTIMORE		13c. CITY OR TOWN EASTWOOD	
14 FATHER'S NAME FIRST MIDDLE LAST BENJAMIN PASKIEWICZ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS 5623 GERLAND AVE. WILLIAM KOBOKOVICH ; BALTO., 21206, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 436- DUE TO, OR AS A CONSEQUENCE OF (b) BRAINSTEM COMPRESSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) STROKE							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES 12 HOURS 20 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov 1, 19 79, to Nov 2, 19 79, that (I) (we) last saw the deceased alive on Nov 2, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I) (we) did not view the body after death.							
22b. SIGNATURE Robert S. Fisher MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/2/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT S. FISHER				22e. ADDRESS DEPT OF NEUROLOGY, BALTIMORE CITY			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-5-79		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE 7301 GERMAN HILL RD. BA. CO., MD.	
24. FUNERAL DIRECTOR NAME Charles L. Zeiler & Son, Inc.				ADDRESS 6224 EASTERN AVE. BALTO., 21224, MD.		25a. DATE REC'D. BY REGISTRAR NOV 8 1979	
				25b. REGISTRAR'S SIGNATURE [Signature]			

BP



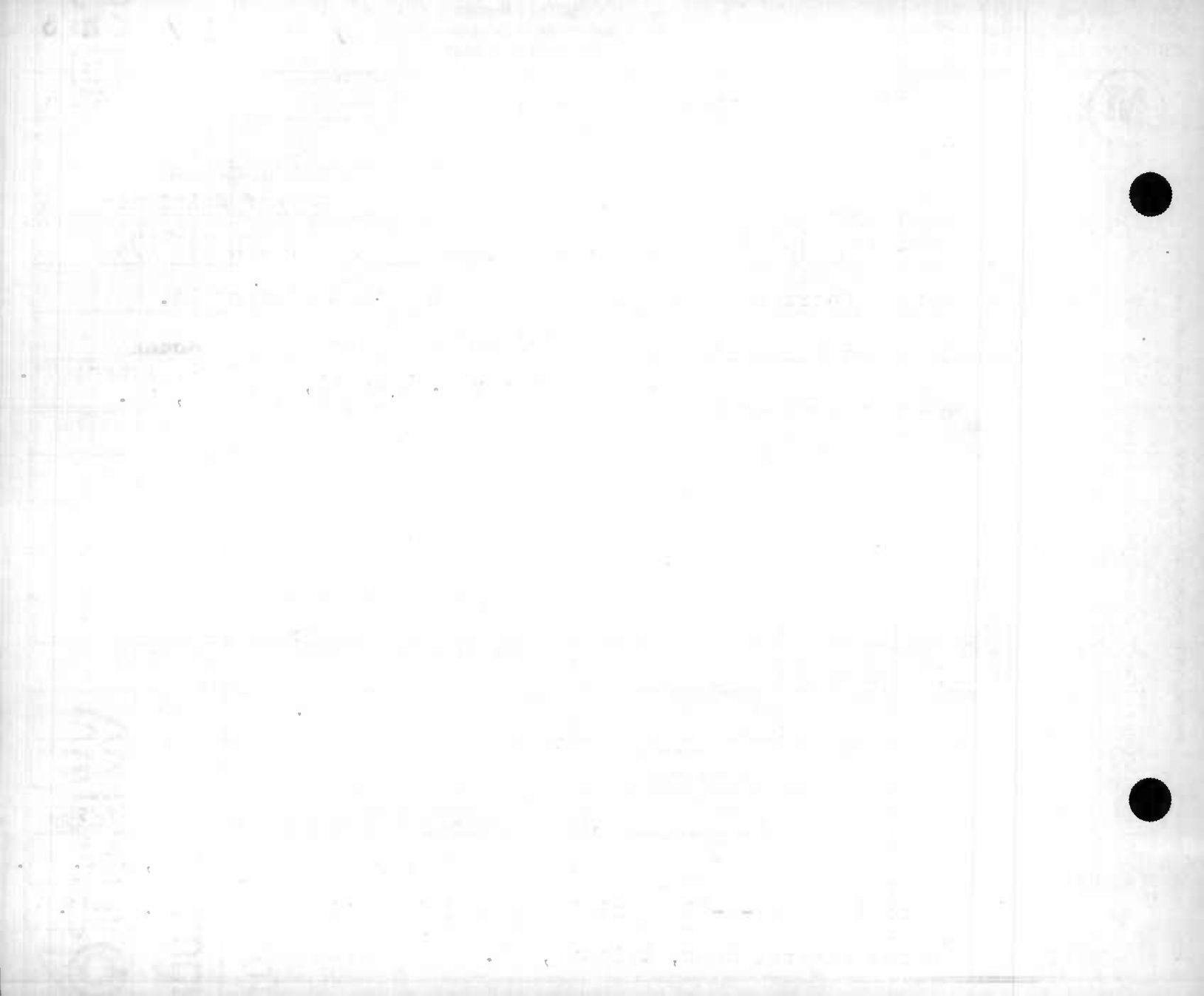
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 1 4 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD Allen BONSALL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 3<sup>rd</sup> 1979</b>		2b. HOUR <b>6:15 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 30 78</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>One</b> YRS. <input type="checkbox"/> IF UNDER 1 YEAR MONTHS <input type="checkbox"/> IF UNDER 24 HRS. DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY of Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MT. Washington Pediatric Centre</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Not applicable.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS <b>2104 Gibbons Ct.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Waldorf</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY Lynn BONSALL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JANET Ann Hodge</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>-</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>2104 Gibbons Ct. Harry L. Bonsall, Waldorf, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b>							
<div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <p>0543</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost</p> </div> <div> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTING HEART FAILURE AND CNS DAMAGE</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <b>HERPES ENCEPHALITIS</b></p> </div> </div>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>RENAL FAILURE</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that <b>HE</b> (this hospital) attended the deceased from <b>10/19/1979</b> , to <b>11/3/1979</b> , that (I) (we) last saw the deceased alive on <b>11/3/1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M. Kulathunga</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. KULATHUNGAM</b>				22e. ADDRESS <b>MT. Washington Pediatric Centre, Balt. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-6-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf Chas. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home,</b> ADDRESS <b>Waldorf, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 08 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Hickory McCreedy</b>	





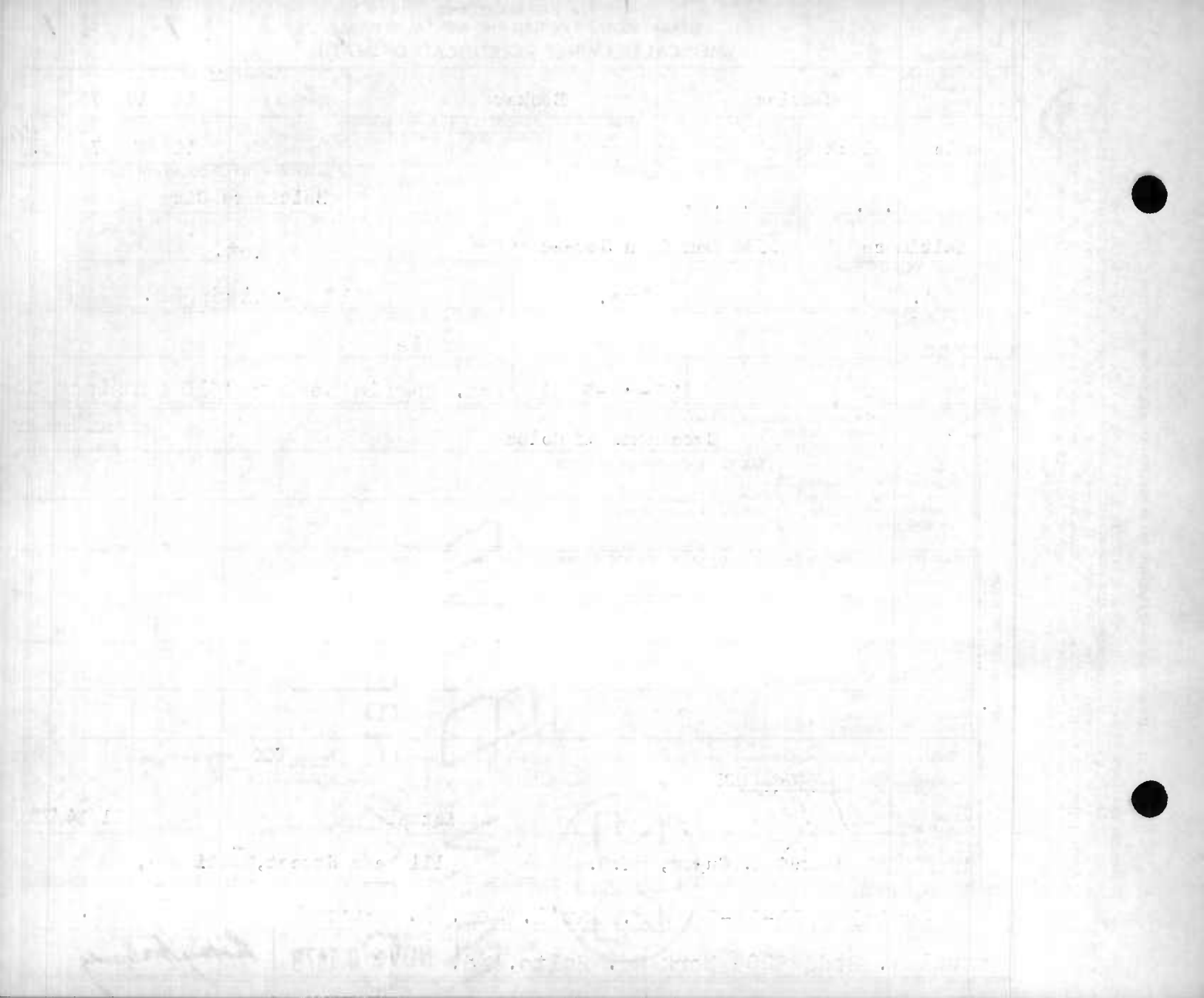


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		7 9 2 7 1 4 7	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
Charles Booker		XX MONTH DAY YEAR ESTIMATED 11 10 19 79	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
male	black	5 22 08	71 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH
S.C.	U.S.A.	NEVER MARRIED WIDOWED	Baltimore City
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	3510 Dennison Street Road	Ret.	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Md.		Balto.	YES X NO
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT ADDRESS	
James Booker	Addie	Mrs. Maggie Booker 3510 Dennison Rd	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
NO	237-32-7331	Mrs. Maggie Booker 3510 Dennison Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 1539 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?	
		YES NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
	HOUR A.M. MONTH DAY YEAR P.M. 19		
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION	
		CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner			
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Homrez R. Guard, M.D.		Assistant	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Homrez R. Guard, M.D.		11/14/79	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Burial	11-15-79	Md. Nat'l. Mem. Pk.	Laurel
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Samuel T. Redd 5209 York Rd. Balto. Md.		NOV 20 1979	Robert A. Brady



7 9 2 7 1 4 8

REG. NO.

once.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED 11/17/1971

RECEIVED

RECEIVED

NOVEMBER 16, 1971 00:30

BALTIMORE CITY

THE JAMES HOPKINS HOSPITAL

1000 N. JACOB

NOVEMBER 16, 1971 00:30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the file for the deceased. Page 3 should be filed in the file for the funeral home. Page 4 should be filed in the file for the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 1 4 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM H. BOOTHE JR.				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 27, 1979				2b. HOUR 04:30pm			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 20, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Int. Rep.		12b. KIND OF BUSINESS OR INDUSTRY Labor			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Balto.		13c. CITY OR TOWN White Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1415 Central Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Boothe Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eathel Pennington							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT ADDRESS Myrna F. Boothe, White Hall, Md. 21161					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uncharacterized Lymphoproliferative Myeloid</u> 5/79 DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-25</u> , 19 <u>79</u> , to <u>4<sup>30</sup> 11/27</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>4<sup>30</sup> 11/27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Thomas Nysaard</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-27-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Nysaard				22e. ADDRESS 601 N Broadway JHH							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-1-1979		23c. NAME OF CEMETERY OR CREMATORY Vernon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE White Hall Balto. Md.			
24. FUNERAL DIRECTOR NAME H. Hartenstein				ADDRESS New Freedom, Pa.				25. DATE REC'D. BY REGISTRAR DEC 3 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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10

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 5 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Rudolph</i>			FIRST <i>=</i> MIDDLE <i>=</i> LAST <i>Borke</i>			2a. DATE OF DEATH MONTH <i>11</i> DAY <i>13</i> YEAR <i>79</i>			2b. HOUR <i>12 55</i> P. M.		
3. SEX <i>MALE</i>			4. RACE <i>Ca.</i>			5. DATE OF BIRTH MONTH <i>7</i> DAY <i>22</i> YEAR <i>18</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS. # UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> # UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Hungary</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UNION MEMORIAL HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Purchasing Agent</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Office Equip.</i>		
13a. STATE <i>BALTIMORE</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST <i>Rudolph</i> MIDDLE <i>Borke</i> LAST <i>Borke</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Helen</i> MIDDLE <i>Piros</i> LAST <i>Piros</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>31-41--3130</i>		
17. INFORMANT ADDRESS <i>Marylou Sheppard 2806 Greenlawn Rd.</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 436- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>POSSIBLE SHOCK</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION <i>11/3/79</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ARTERIAL OCCLUSION INJECTION</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22. I certify that (I) (this hospital) attended the deceased from <i>Oct 14</i> , 19 <i>79</i> , to <i>Nov 3</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>Nov 3</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <i>Shuler M.D.</i> DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22c. DATE SIGNED <i>11/3/79</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. KOEHLER</i>			22e. ADDRESS <i>UNION MEMORIAL</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		
23b. DATE <i>11/5/79</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Balto.</i> COUNTY <i>Baltimore</i> STATE <i>Md.</i>			24. FUNERAL DIRECTOR NAME <i>Stearnsbury, John J. Jr.</i> ADDRESS <i>Woodlawn, Md.</i>		
25a. DATE RECEIVED BY REGISTRAR <i>NOV 13 1979</i>			25b. REGISTRAR'S SIGNATURE <i>K. J. J. Jr.</i>			25c. REGISTRAR'S NAME <i>K. J. J. Jr.</i>			25d. REGISTRAR'S ADDRESS <i>Woodlawn, Md.</i>		

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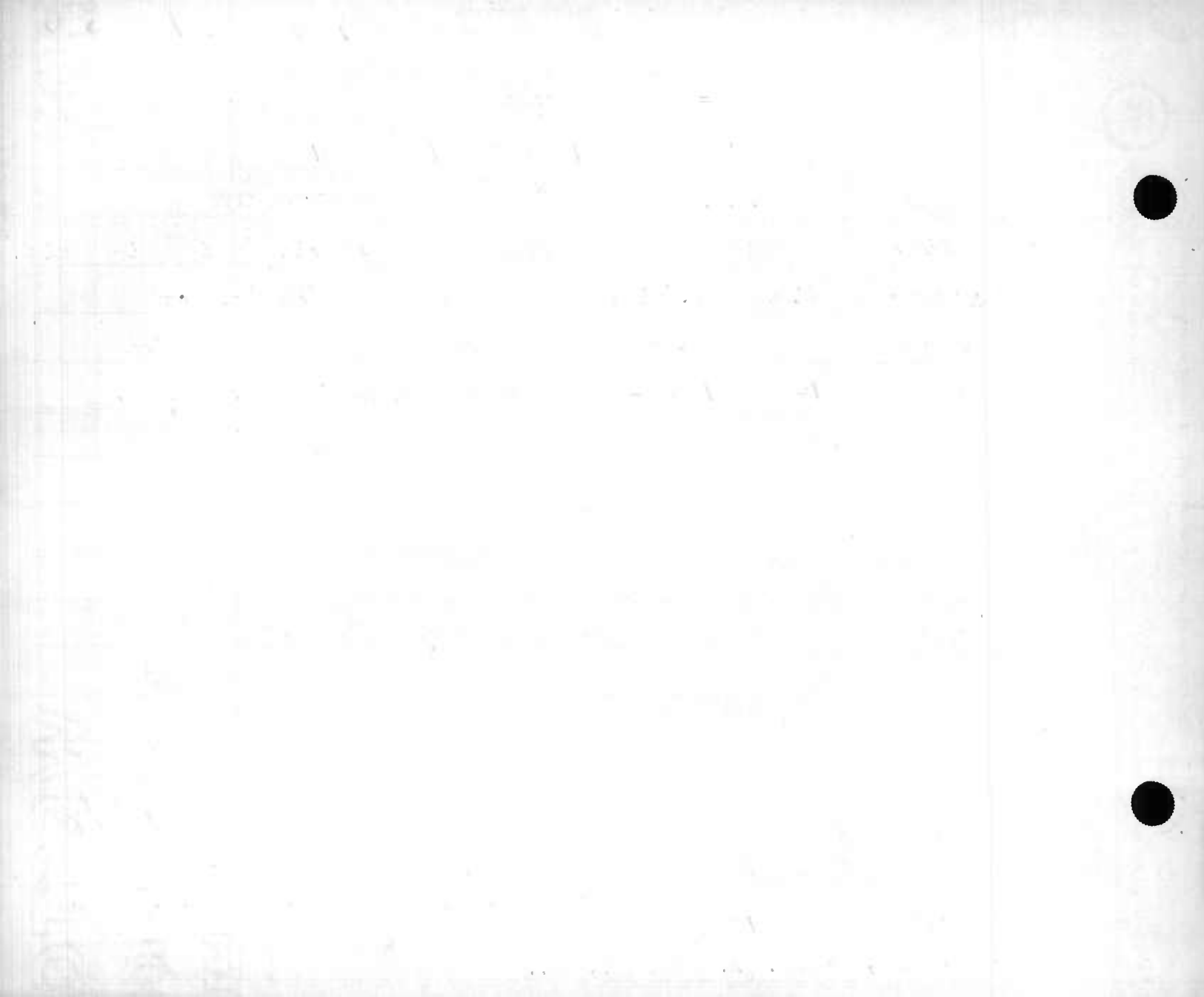
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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(VRA 15, 4) 7/78





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27151	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR	
Wayne Kirkland Bowerman								KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11 21 19 79		M 3:10 A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	White	Mar. 22, 1960		19 YRS.						11 21 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		University Hospital (STU)				Construction and		School			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Baltimore		White Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3227 Old York Road			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Hammond Richard Bowerman				FIRST MIDDLE LAST Ann Wiggers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				216-78-7330		Mr. Dick Bowerman same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				1:35 PM 11 21 19 79		Driver of auto/fixed object impact					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
				street		Rt. 23 Shawsville, Harford, Md. STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) Assistant				DATE SIGNED 11/21/79			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/24/79		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR NOV 26 1979		25b. REGISTRAR'S SIGNATURE			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kelly DeNae Boyd										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> MONTH DAY YEAR 11 9 19 79										2b. HOUR M 4:55A	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 23 79		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 3		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 9 19 79		7d. HOUR M		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE Md.				13b. COUNTY Balto.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 3854 Sincalir Lane									
14. FATHER'S NAME FIRST MIDDLE LAST Everette Boyd						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah McGurie															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT Deborah Boyd				ADDRESS 3854 Sincliar La.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Sudden Infant Death Syndrome</u> 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief										DATE SIGNED 11/9/79							
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/12/79				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.									
24. FUNERAL DIRECTOR NAME Wm C March F/H								ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR NOV 13 1979				25b. REGISTRAR'S SIGNATURE <i>Richard H. Brady</i>					



10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 2 7 1 5 3				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH (MONTH DAY YEAR)				
Minnie Virginia Branham Minnie Virginia Branham					November 14, 1979 11 14 '79 5:15 A M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		Jan. 22, 1890 01 22 90		89 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Baltimore		South Baltimore General Hosp							
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
House wife		Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Maryland		Baltimore		English Council		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
Sidney C. Johns		Mary Eler Terry		No N/A 212-74-3002					
16b. SOCIAL SECURITY NO.		17. INFORMANT (son) ADDRESS							
212-74-3002		32 Hampton Rd. Mr. Thomas E. Branham Linthicum, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac insufficiency . . CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic brain syndrome Hypertensive Cardiovascular disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 min. 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-01</u> 19 <u>79</u> to <u>11-14</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE						22c. DATE SIGNED	
Myeung Gim Lim		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Myeung Gim Lim		South Baltimore General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		November 17, 1979		Glen Haven Mem. Pk		Glen Burnie A.A. Md.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
R. N. Hopkins		Singleton Funeral Home, Glen Burnie, Md.		NOV 16 1979		[Signature]			

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The attending physician and completely filled in by the funeral director should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. If the death is a reportable event, the medical examiner must be notified at the time of the death. If the death is a reportable event, the medical examiner must be notified at the time of the death. If the death is a reportable event, the medical examiner must be notified at the time of the death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 5 4

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD</b>		P		LAST <b>BRENISH</b>		2a. DATE OF DEATH MONTH <b>11</b> DAY <b>8</b> YEAR <b>79</b>		2b. HOUR <b>1:45 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Jan.</b> DAY <b>7</b> YEAR <b>1937</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>-</b> 13c. CITY OR TOWN <b>Baltimore</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1703 St. Paul Street</b>			
14. FATHER'S NAME FIRST <b>Pete</b> MIDDLE <b>Brenish</b> LAST <b></b>						15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Peron</b> LAST <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>207 28 8973</b>		17. INFORMANT <b>Mary King, Mother</b>		ADDRESS <b>Shelby, N.C. 517 South DeKalb St</b>					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>5715</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>HEPATIC ENCEPHALOPATHY</b> (c) <b>CIRRHOSIS OF THE LIVER</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>MASSIVE ASCITES AND JAUNDICE, GASTRO-INTESTINAL BLEEDING</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>11-7</b> , 19 <b>79</b> , to <b>11-8</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11-8</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Joseph Mac Mahon</b>						DEGREE		22c. DATE SIGNED <b>11-8-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. JOSEPH MACMAHON</b>						22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 21231 100NORTH BROADWAY, BALTIMORE, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/13/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>Brudzinski Funeral Home PA 1407 Old Eastern Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

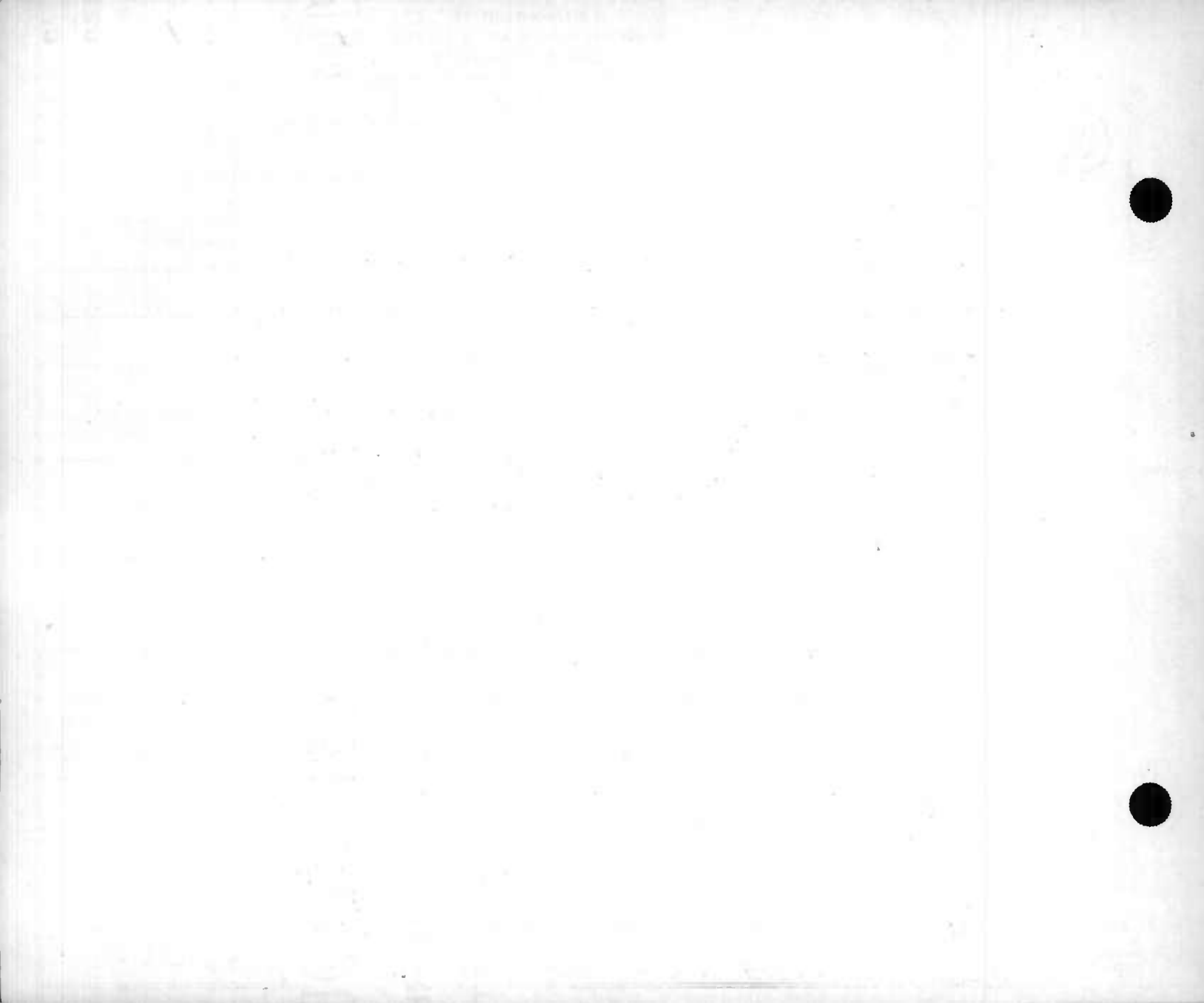
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

2 7 1 5 5

REG. NO.

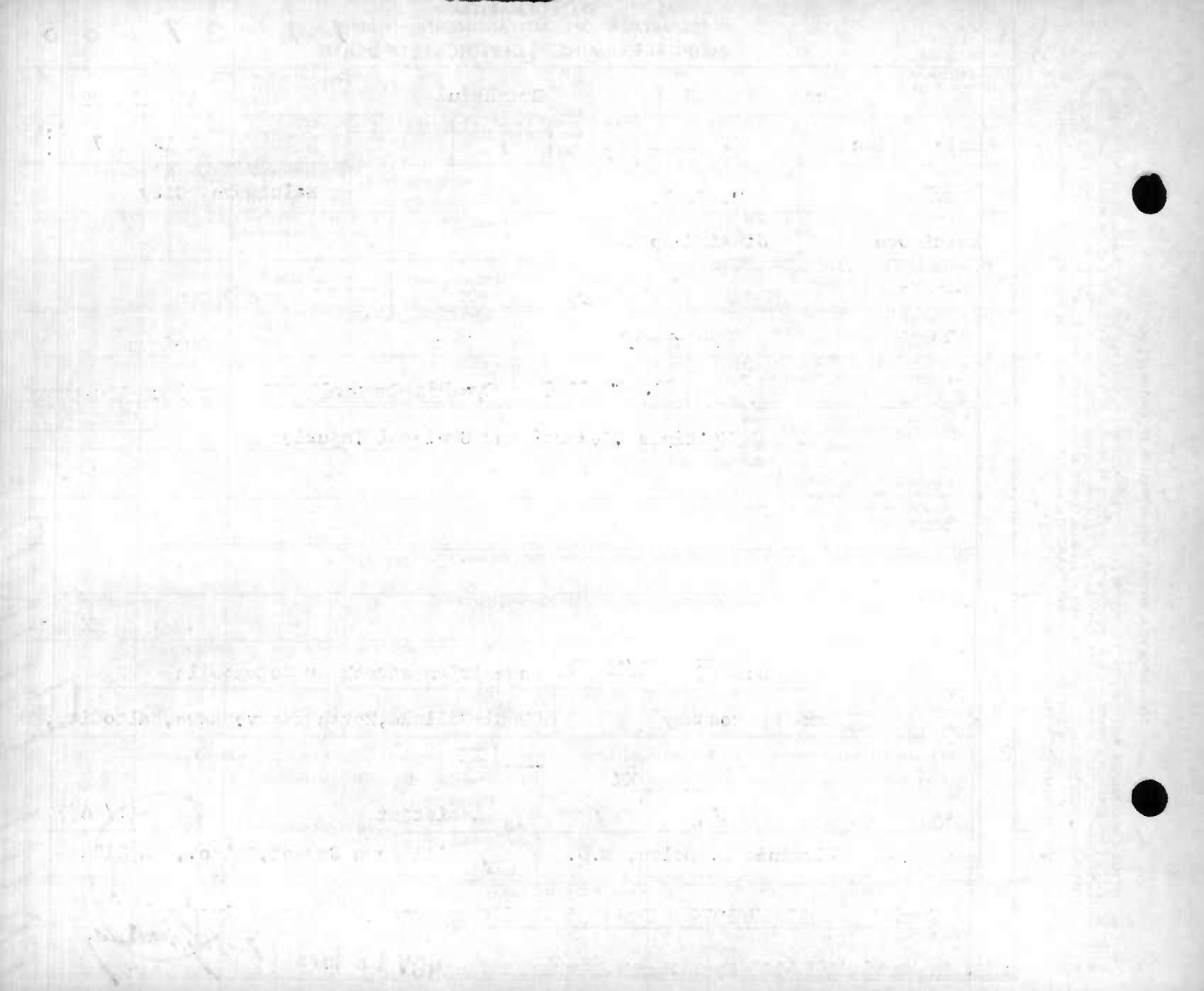
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
MARY		F.		Brewington				11-5-1979					8 <sup>15</sup> P <sup>M</sup>	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		COL		MAY 2, 1900				79		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH						
BALTO. MD		U.S.A						BALTIMORE CITY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE		John L Deaton Med. Center						HOMEMAKER						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. CITY OR TOWN		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS				
13a. STATE						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		600 S. LIGHT ST		APT 209		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME								
14a. FIRST						14b. MIDDLE		14c. LAST		15a. FIRST		15b. MIDDLE		
ALLEN F. GLEN										MARY JONES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
NO						217 03 5056 B		MR JOSEPH BREWINGTON		600 S. LIGHT ST				
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Renal Failure</u> 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 5</u> , 19 <u>79</u> , to <u>Nov 5</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Nov 5</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Julian W Reed</u>								DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/7/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JULIAN W. REED</u>								22e. ADDRESS <u>611 S. CHAS. ST. BALTO. MD 21201</u>						
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL				11-9-79		ARBUTUS MEM PARK				ARBUTUS BALTO. CO. MD				
24. FUNERAL DIRECTOR NAME								ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Joseph L. Reed 22226 NORTH AVE										NOV 15 1979		<u>[Signature]</u>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										7 9 2 7 1 5 6 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Oden H Brightful						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 11 13 19 79		2b. HOUR 6:45 P. M.			
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 2 22 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1917 Monroe Street	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Brightful						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sanders					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-05-6980		17. INFORMANT ADDRESS Cynthia Campbell 2230 Garrison Boulevard					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Visceral and Skeletal Injuries 8147 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 4:58 P.M. 11/13 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by automobile					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5000 Blk Falls Rd, North of Harvest Ave, Balto City, MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) Assistant				DATE SIGNED 11/14/79			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/17/1979		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 East North Avenue						25a. DATE REC'D. BY REGISTRAR NOV 16 1979		25b. REGISTRAR'S SIGNATURE			

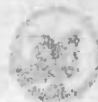


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 7 1 5 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Howard NMN Brimmer</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>11 8 '79</i>		2b. HOUR <i>9:40 A M</i>	
3. SEX <i>Male</i>		4. RACE <i>White.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 11 09</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>70 YRS</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore City</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Baltimore Gen. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Lumber Yard</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE <i>Md.</i>			
13b. COUNTY <i>---</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Howard Brimmer, Sr.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Lizzie Rodeman</i>		13e. STREET ADDRESS <i>4026 Pennington Avenue</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW II</i>		17. INFORMANT ADDRESS <i>Balto., Md. 21225</i>			
16c. <i>213-01-1408</i>		17. <i>Mrs. Nellie Milewski</i>		17. <i>4001 Orchard Ave.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple organ failure</i> 5325 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Shock, renal failure, peritonitis</i> (c) <i>perforated duodenal ulcer and occlusion</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <i>11-2-'79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Sigmoid-ileal fistula and pelvic abscess due to diverticulitis</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10-26</i> , 19 <i>79</i> , to <i>11-8</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11-8</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Kazuaki Okubo</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>11-8-'79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kazuaki Okubo</i>				22e. ADDRESS <i>3001 S. Hanover St. Balto. Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/13/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie AA Maryland</i>	
24. FUNERAL DIRECTOR <i>Mc Cully Funeral Home of Curtis Bay</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 14 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert McHenry</i>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 5 8

FOR  
STATE  
REGISTRAR

REG. NO.

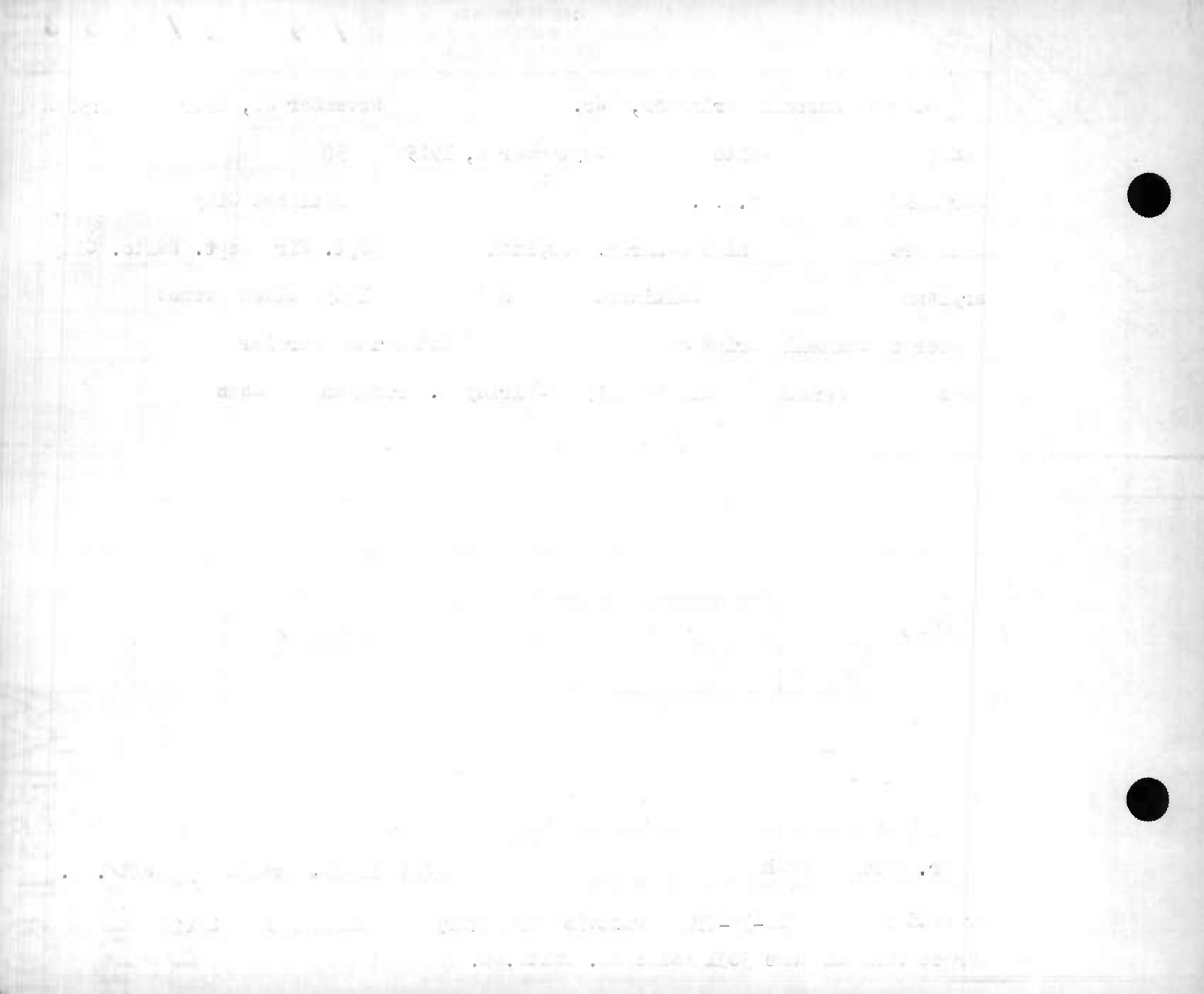
1. DECEASED NAME (TYPE OR PRINT) <b>George Russell Brinkman, Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 26, 1979</b>			2b. HOUR <b>8:58 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 8, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>50</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN. <b>50</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Capt. Fire Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) (3a) STATE (3b) COUNTY <b>Maryland</b> <b>Baltimore</b>				13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1365 Weldon Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Russell Brinkman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Burrier</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean</b>		17. INFORMANT ADDRESS <b>Shirley L. Brinkman Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma lung.</b> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION <b>9/26/79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/1</b> , 19 <b>79</b> , to <b>11/26</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>9/24</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Karl F. Nech, Jr.</b> M.D. DEGREE						22c. DATE SIGNED <b>11/27/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Karl Nech</b>						22e. ADDRESS <b>3350 Wilkins Avenue Balto. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>11-30-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md 21228</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Burge Funeral Home 3631 Falls Rd. Balto. Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia K. Brady</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 5 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST LENA		MIDDLE	LAST BRISCOE	2a. DATE OF DEATH		MONTH 11	DAY 06	YEAR 79	2b. HOUR 8 50 AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 6 DAY 07 YEAR 86		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1921 McHENRY ST.				
14. FATHER'S NAME FIRST WILLIAM MIDDLE LAST DUTCH		15. MOTHER'S MAIDEN NAME FIRST SALLY MIDDLE LAST SHERLOCK		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-74-2235		17. INFORMANT ARTHUR FRANKE, 5 SECOND AVENUE		ADDRESS FERDALE, MD. 21061		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 5334 UPPER GASTROINTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF (b). STRESS ULCER DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 2 DAYS												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ASCVD - CONGESTIVE HEART FAILURE												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 10-13 19 79 to 11-06 19 79, that (I) (we) lost saw the deceased alive on 11-05 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Oscar E. Ferdinandini M.D.		DEGREE M.D.		22c. DATE SIGNED 11-06-79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSCAR E. FERNANDINI M.D.		22e. ADDRESS 2025 W. FAYETTE ST. BALTO. MD. 21223				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-08-79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN BROOKLYN PARK A.A. MD.		23e. DATE REC'D. BY REGISTRAR NOV 7 1979				
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.,		ADDRESS 21229 4107 WILKENS AVE.		24b. REGISTRAR'S SIGNATURE [Signature]								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 212-2123.

UBB 30 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMM - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		11		3 79 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		B		MONTH 3 DAY 31 YEAR 13		66 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pa.		USA				Baltimore City				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Balto.		3601 Edmondson Avenue									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3601 Edmondson Ave.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Raymond		Sampson		Lula		Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		220-01-2425		George N. Briscoe		3601 Edmondson St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF									
1749		Pulmonary complications									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		Metastatic carcinoma of the breast							
		DUE TO, OR AS A CONSEQUENCE OF									
		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
NA.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
NA.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR		NA.							
		P.M.		19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from		19 28		to present		19					
saw the deceased alive on		Summer		19 27		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
Larry Waterbury, M.D.				11/6/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
LARRY WATERBURY, M.D.		BALT. CITY HOSPS., BALT., MD. 21224									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		11/8/79		Arbutus Mem. Pk.		Arbutus, Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME		ADDRESS									
Win C March F/H		1101 E. North Ave.		NOV 7 1979		Duffy/Kelley					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR					5- STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 2 7 1 6 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) CHARLES JOSEPH. BROCATO					2a. DATE OF DEATH MONTH 11 DAY 1 YEAR 79					2b. HOUR 10 45 P M				
3 SEX Male		4 RACE WHITE		5 DATE OF BIRTH MONTH 9 DAY 14 YEAR 93		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.								
10 CITY OR TOWN OF DEATH Balto. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balt Gen Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY A.A. Co.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 207 Creswell Rd.			
14 FATHER'S NAME FIRST MIDDLE LAST Brocato					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. W.W. 218 34 7014		17 INFORMANT ADDRESS Sadie Brocato same as 13 e							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 496- DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease 10 years DUE TO, OR AS A CONSEQUENCE OF (c) and Pneumonia 1 week.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION 10/13/79.					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumothorax.					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10/3, 19 79, to 11/1, 19 79, that (I) (we) lost saw the deceased alive on 11/1, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Mundra					DEGREE MD					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/1/79.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURYA P. MUNDRA					22e. ADDRESS South Balt Gen Hosp									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 11/5/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.				
24 FUNERAL DIRECTOR NAME George J. Gonce					ADDRESS 4001 Ritchie Hwy		BALTO 21225		DATE REC'D BY REGISTRAR NOV 6 1979		SIGNATURE [Signature]			

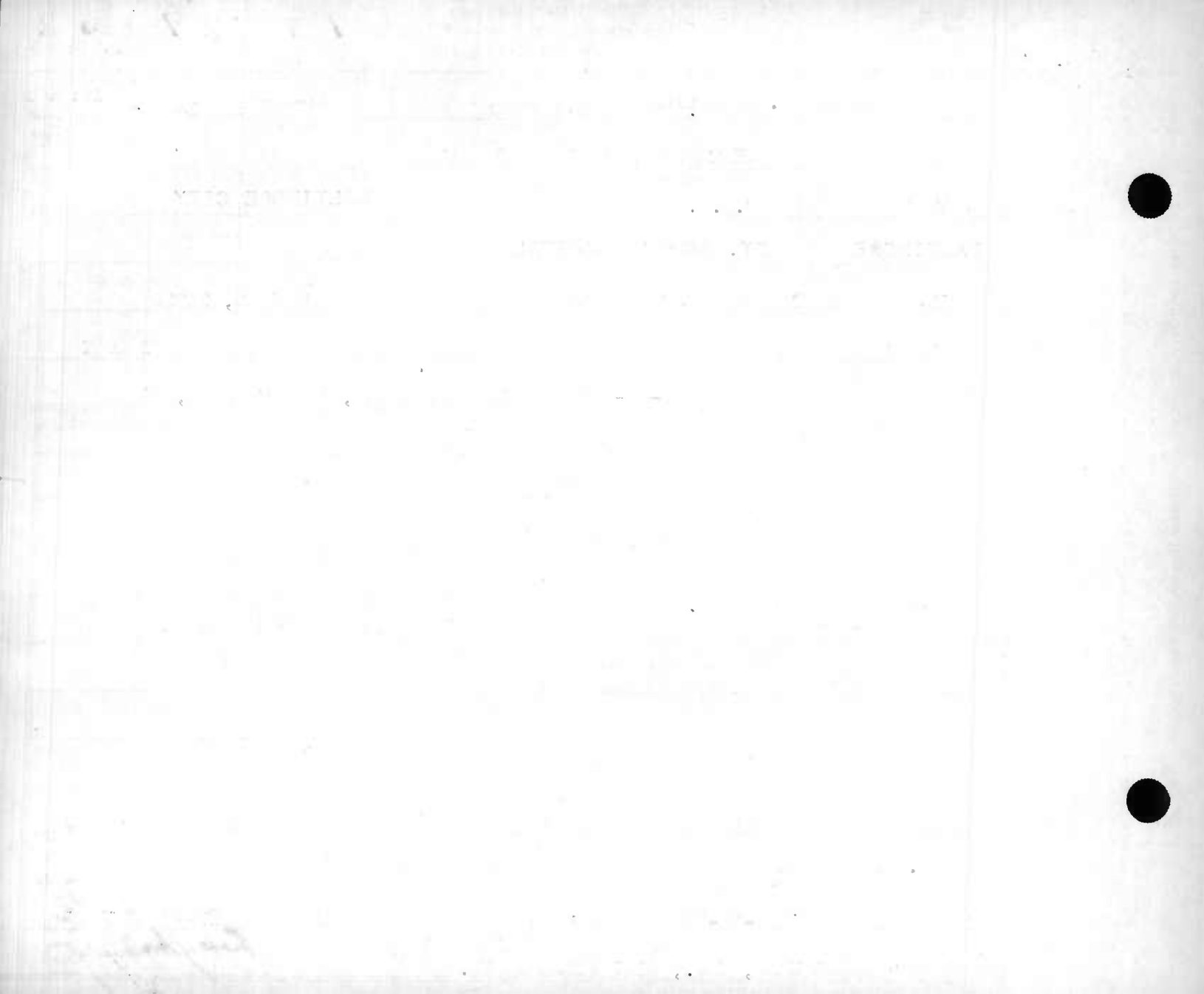




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1- STATE REGISTRAR										2- DATE OF DEATH										3- HOUR																																																																					
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH										2b. HOUR																																																																					
WOODROW C. BRODERICK										11 18 79										10:50 A																																																																					
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS LAST BIRTHDAY)										7. IF UNDER 1 YEAR										8. IF UNDER 24 HRS																																							
MALE										WHITE										11 07 12										67 YRS.										MONTHS										DAYS										HOURS										MIN.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH										10. MD.																																																	
MARYLAND										U.S.A.																				BALTIMORE CITY																																																											
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																											
BALTIMORE										ST. AGNES HOSPITAL										SALESMAN																																																																					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																																																	
MARYLAND										BALTIMORE										CATONSVILLE										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										6 LODGE ROAD, 21228																																																	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																																							
GEORGE										ALICE										NO										212-05-7069										GRAYCE BRODERICK, 6 LODGE ROAD, 21228																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										18a. IMMEDIATE CAUSE (a)										18b. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										18c. DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
5370										Cardiac arrest										Stroke																																																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										19. DATE OF OPERATION										19a. CONDITION FOR WHICH OPERATION WAS PERFORMED										19b. AUTOPSY?										19c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																																																	
										11/14/79										Closure colostomy										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input type="checkbox"/>																																																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. TIME OF INJURY										20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																																																											
										P.M. 19																																																																															
21a. INJURY OCCURRED										21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										21c. LOCATION										CITY OR TOWN										COUNTY										STATE																																							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																																																																																									
22a. I certify that (I) (this hospital) attended the deceased from										22b. SIGNATURE										DEGREE										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										12c. DATE SIGNED																																																	
saw the deceased alive on										11/18/79										19 79										10/16										19 79										10/18/79										19 79																													
above, (I) (we) (did) (did not) view the body after death.																																																																																									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS										23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION										CITY OR TOWN										COUNTY										STATE									
Dr. Flazaronte										84 Abner Hospital										ENTOMBMENT										11-21-79										LOUDON PARK										BALTIMORE CITY										BALTIMORE CITY										MARYLAND																			
24. FUNERAL DIRECTOR NAME										24b. ADDRESS										25. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE										26. DATE OF DEATH										26b. HOUR																																							
HUBBARD FUNERAL HOME, INC.,										4107 WILKENS AVE.										NOV 9 1979																																																																					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

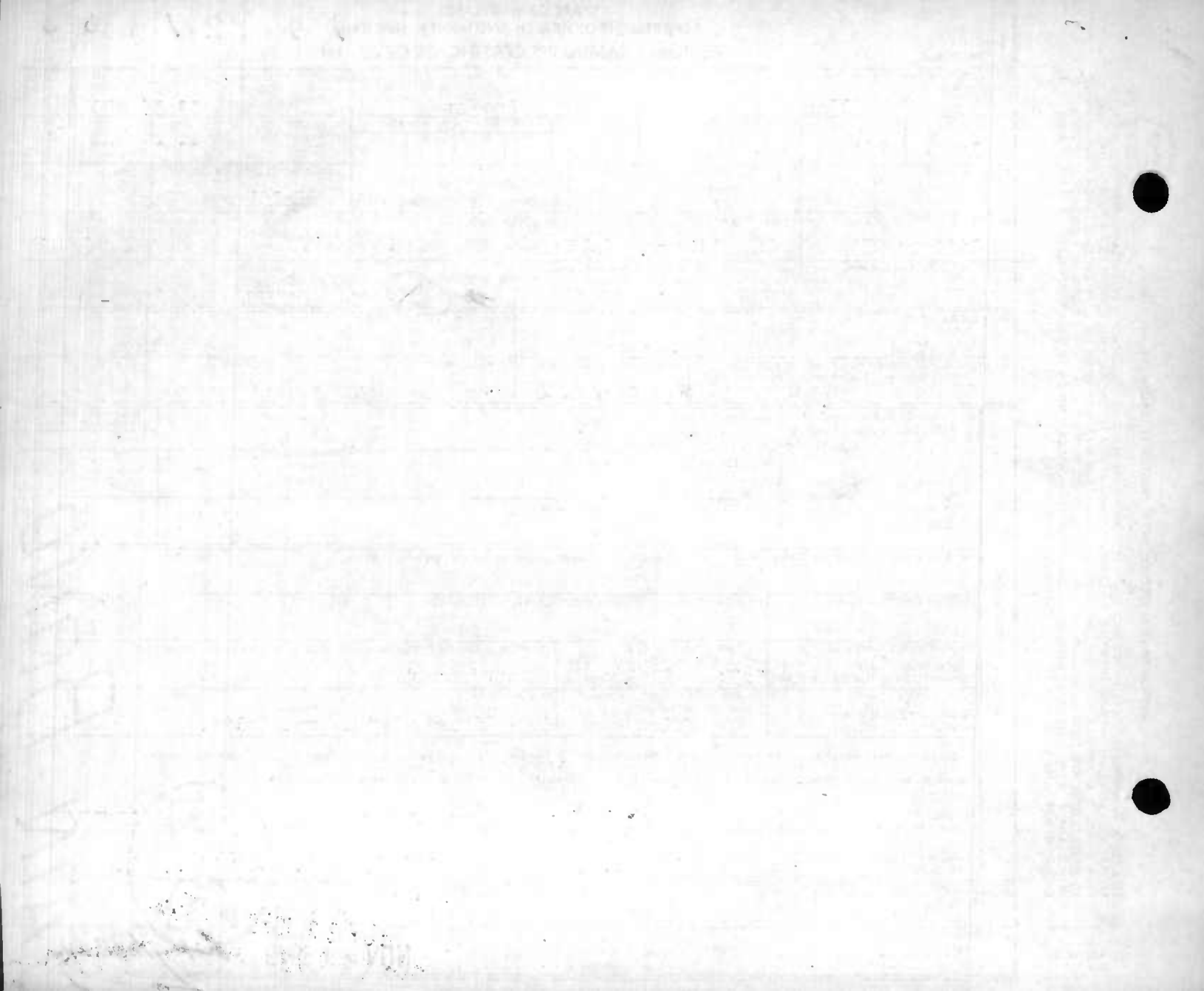
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DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

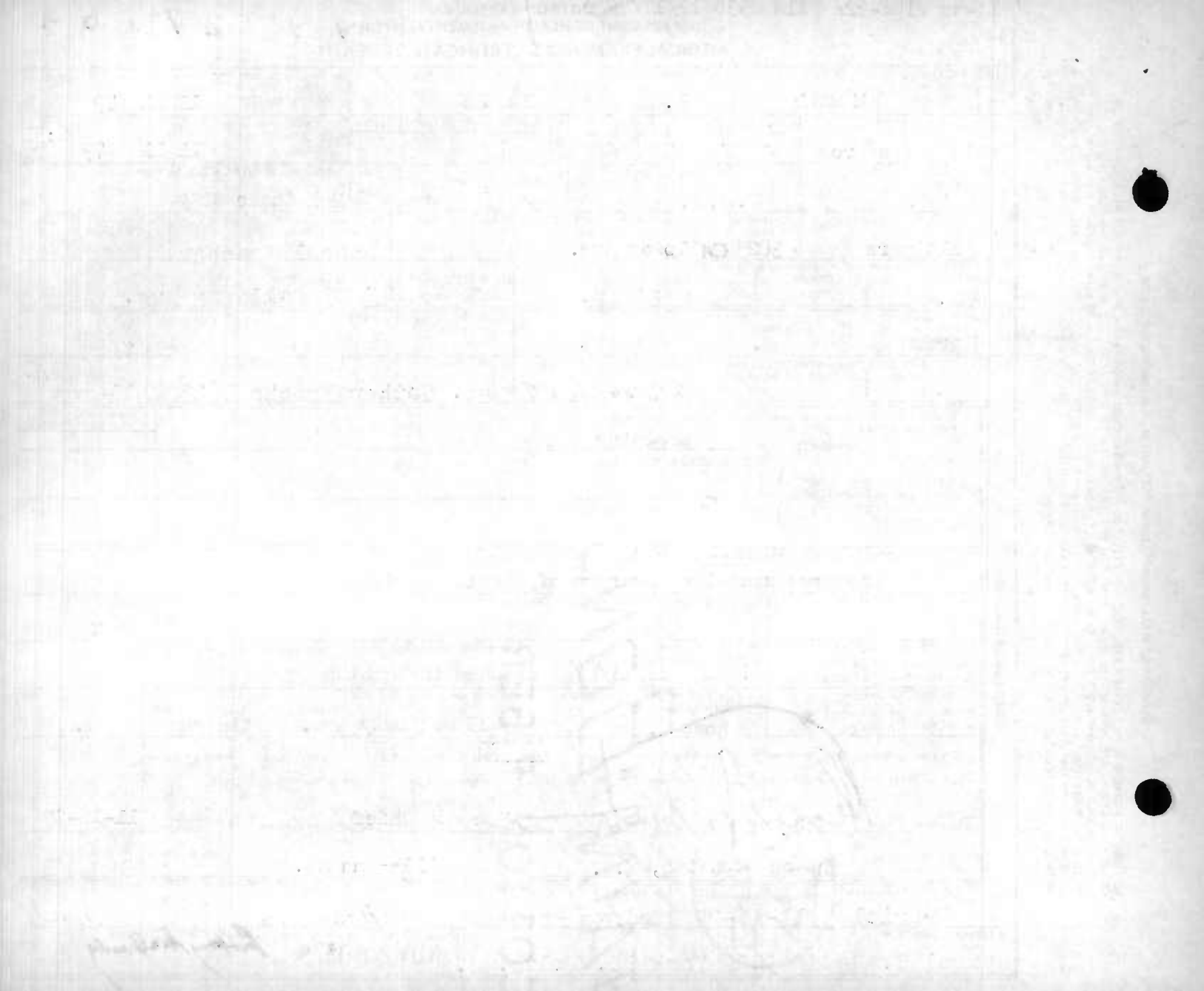
REG. NO.

1. FOR STATE REGISTRAR		7 9 27 16 3	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST Allen MYER Brooks		MONTH DAY YEAR 11 16 1979	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)
Male	White	FEB. 23, 1915	64 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
VIRGINIA		USA	9. BALTIMORE CITY OR COUNTY OF DEATH
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Baltimore City		4808 Liberty Heights	PROPRIETOR
13a. STATE		13b. CITY OR TOWN	13c. INSIDE (CITY LIMITS?)
MARYLAND		BALTIMORE	PIKESVILLE
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
HARRY BROOKS		JEANETTE HORWITZ	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
YES		WWII -NAVY 213-01-1722	
17. INFORMANT		ADDRESS	
MRS. RUTH BROOKS		3414 MIDFIELD RD. (21208)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Gunshot wound of chest 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. BODY ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 5:30 P.M. 11 16 1979	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		subject shot	
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
Office		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4808 Liberty Hgts. Ave. Balto. MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		TITLE (SPECIFY) Deputy Chief	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Thomas D. Smith, M.D.		11/17/79	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BURIAL		11/18/79	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
ANSHE EMUNAH AITZ CHAIM		BALTIMORE, MD.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
SOL LEVINSON & BROS		NOV 23 1979	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
6010 REISTERSTOWN RD. BALTIMORE, MD. 21215		[Signature]	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #10a-22a Film G538 12/17/79 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9	2 7 1 6 4								
1- STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE KNOWN OF DEATH		2b. HOUR							
HOWARD L. BROOKS										X MONTH DAY YEAR 11 11 1979		M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
male		negro		5 25 29		50 YRS.		MONTHS DAYS		HOURS MIN		11 11 19 79		P M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH							
MD.				U.S.A.				X NEVER MARRIED WIDOWED DIVORCED				Baltimore City MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore				3823 Callaway Ave.				School Teacher											
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
MD.								BALTO.				YES X NO				3823 Callaway Ave.			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
FIRST MIDDLE LAST					FIRST MIDDLE LAST														
Herman P. Brooks					Mary McIntyre														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS									
Yes					216-24-8667					Mrs. Esther Brooks 3823 Callaway Av.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Drowning																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
Ruptured saccular aneurysm of Circle of Willis																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES X NO							
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
X				? P.M. 11/11/79				drowned in bathtub											
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
X				home				3823 Galloway Ave. Baltimore Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes Accident X, Suicide, Homicide, Undetermined manner.																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Thomas D. Smith, M.D.				Deputy Chief				11-12-79											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Thomas D. Smith, M.D.				111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				STATE					
Burial				11-16-79		Saints Rest				HARMON'S				Md.					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Samuel T. Redd				5209 York Rd. Balto. Md.				NOV 20 1979				[Signature]							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 6 5

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST BROOKS BABY BOY (TROY)		MONTH DAY YEAR 11 19 79	
3. SEX		5. DATE OF BIRTH	
MALE BLACK		MONTH DAY YEAR 11 18 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MARYLAND HOSP	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY BALTO	
13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 900 BUNCHE STREET		13f. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST		FIRST MIDDLE LAST TARSHELL BROOKS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
Lillian - Rawlings		900 Bunche	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7708 DUE TO, OR AS A CONSEQUENCE OF (b) PREMATURE + RESP DISTRESS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 HRS.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/18/79, 19 79, to 11/19/79, 19 79, that (I) (we) lost saw the deceased alive on 11/19/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Azam Baig MD		22c. DATE SIGNED 11/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AZAM BAIG MD		22e. ADDRESS UNIV MD HOSP 225 GREENE ST	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		11-23-79	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
17T Auburn Cem		BALTIMORE MD	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
ISAIAH L. BROWN & SON INC. 1913 W. BALTO.		NOV-23-1979	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

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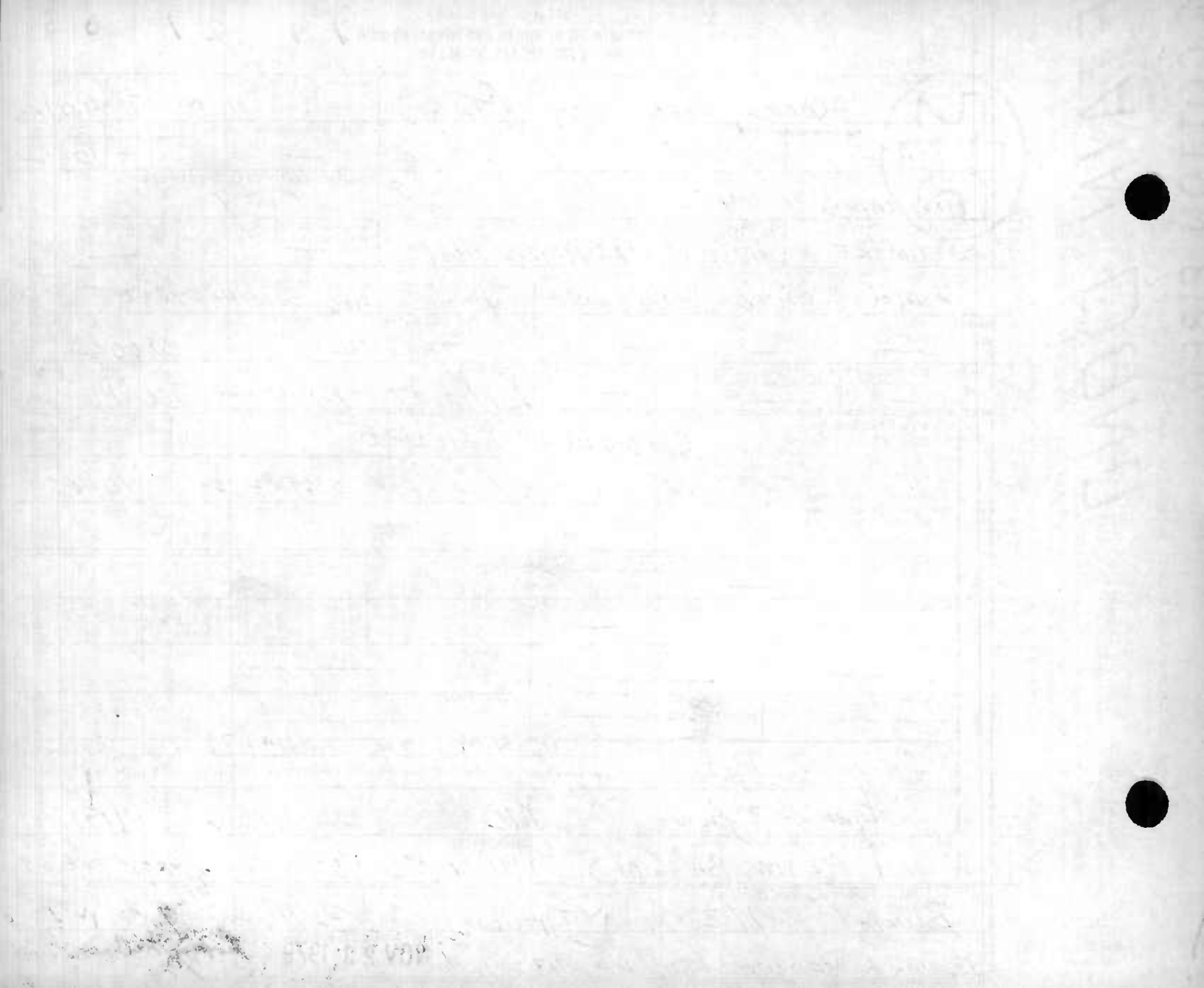
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		7 9 27 16, 6		REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) <del>BROSIOUS F</del> <b>ELsie F. Brosius</b>		3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH <b>3</b> DAY <b>23</b> YEAR <b>77</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		7b. DATE OF DEATH MONTH <b>11</b> DAY <b>11</b> YEAR <b>79</b> 2b. HOUR <b>9</b> P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD		10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>114 N. Highland Ave</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hosp</b>		13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST <b>Francis</b> MIDDLE <b>T.</b> LAST <b>Kesting</b>		15 MOTHER'S MAIDEN NAME FIRST <b>Frederica</b> MIDDLE <b>W.</b> LAST <b>Fuss</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>190-18-3996</b>		17 INFORMANT <b>Nrs Alice Trinks</b>		ADDRESS <b>114 N. Highland Ave</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION</b> <b>1534</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GI BLEEDING</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>1/2 hour</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>10-24-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF CECUM AND SIGMOID COLON</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 24, 1979</b> to <b>NOVEMBER 10, 1979</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 11, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Andrew J. Surmak</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-12</b>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREW J. SURMAK</b>				22c. ADDRESS <b>BALTIMORE CITY HOSPITALS</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-14-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Neodowridge Men</b>		23d. LOCATION CITY OR TOWN COUNTY STATE					
24 FUNERAL DIRECTOR NAME <b>Thelma A. Hoffmann</b>				ADDRESS <b>3218 Hudson St.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia K. [Signature]</b>			



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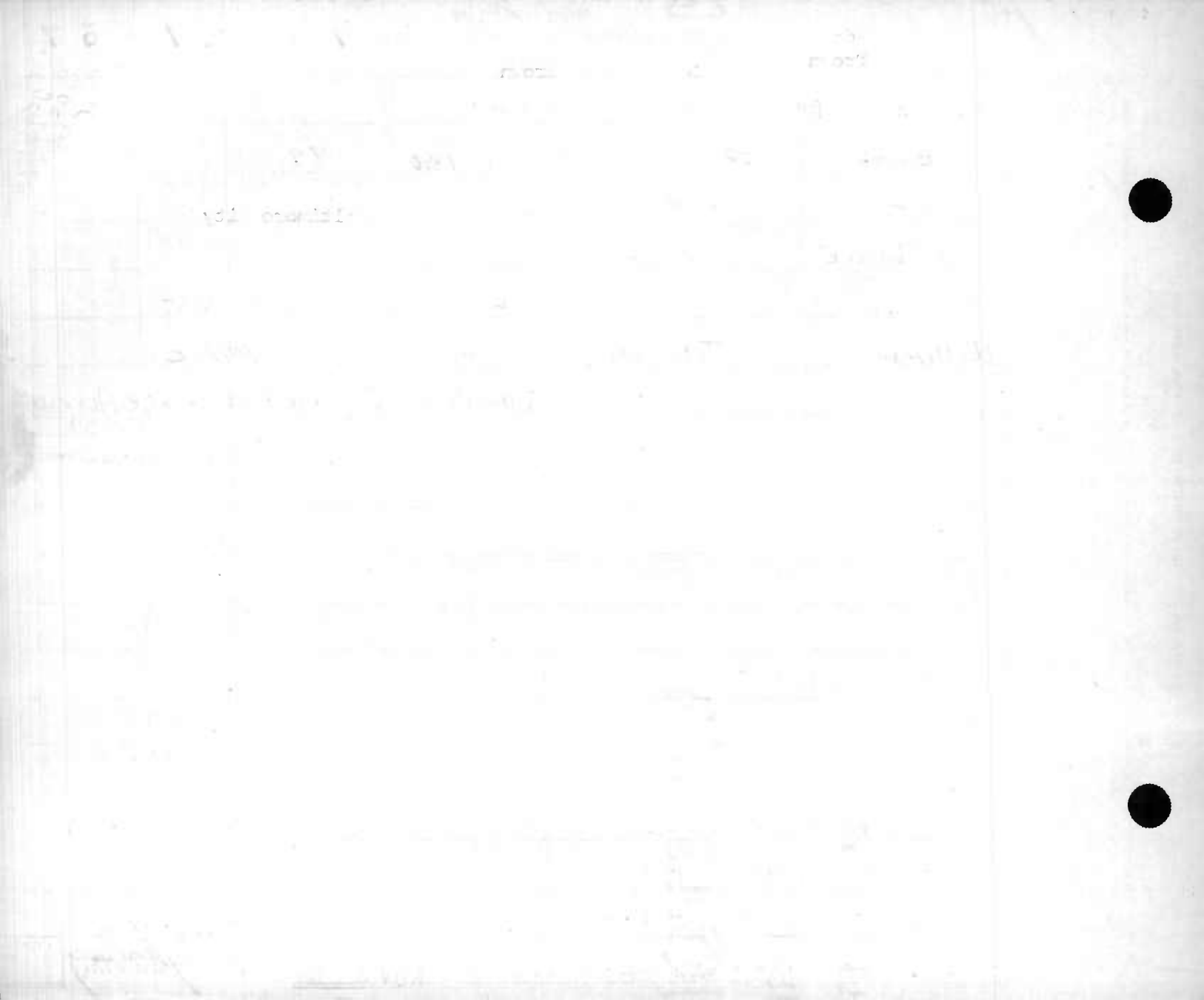


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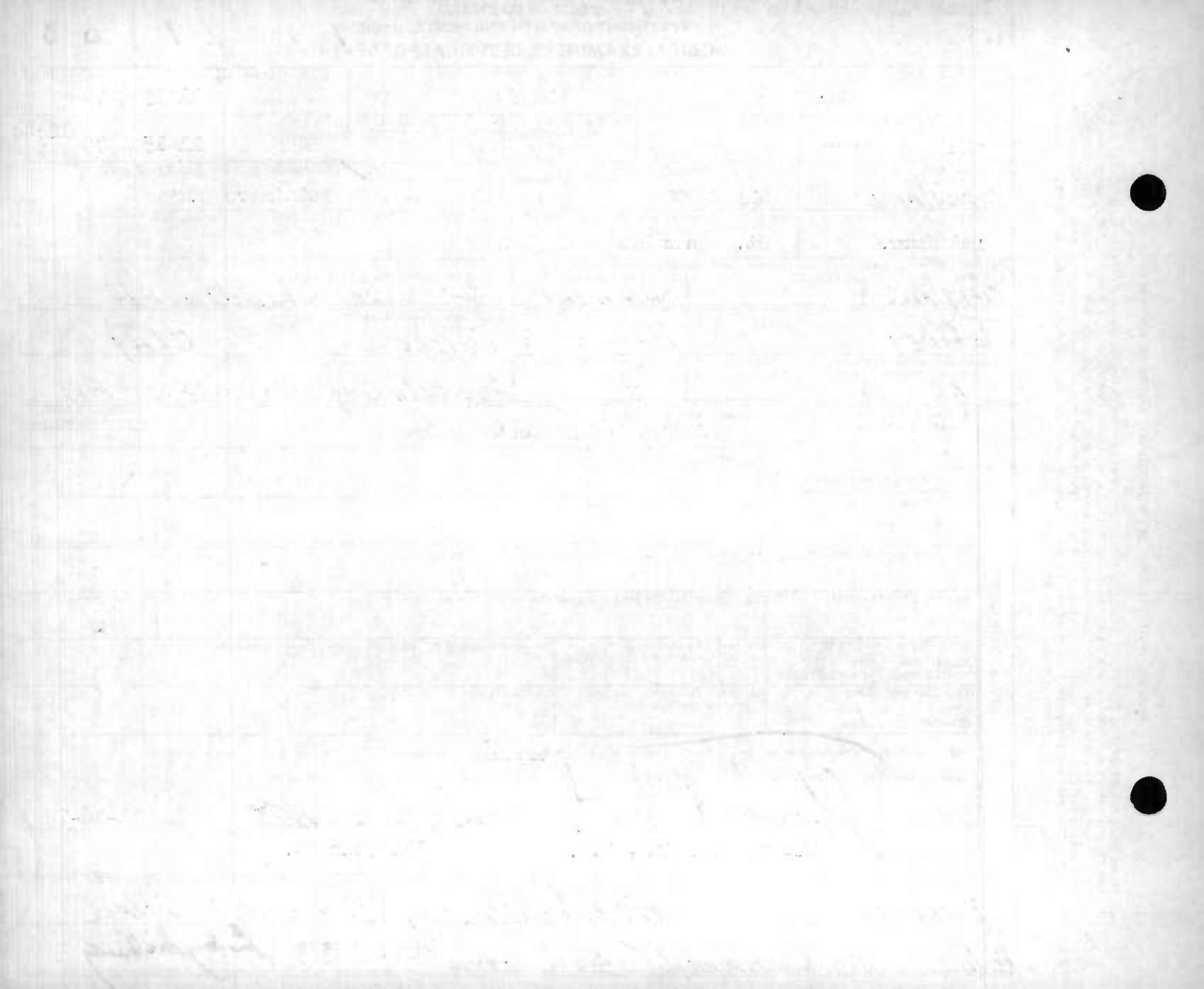
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 1 6 7	
1. FOR STATE REGISTRAR		Ada Brown		B Brown		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a. DATE OF DEATH				2b. HOUR	
Brown ADA B BROWN						11 26 79				2:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		NEGRO		MONTH DAY YEAR 03 08 1890		89 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VA		USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		V M H									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. CITY OR TOWN		13b. STREET ADDRESS					
13a. STATE				13b. COUNTY		13c. INSIDE CITY LIMITS?					
Maryland				BALT.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2010 E 31st			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST William Johnson				FIRST MIDDLE LAST WANZER Mollie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
				21-603-6984		John Brown, Jr. 4507 St. George Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CARCINOMA OF THE CERVIX											
1552 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/25 1979 to 11/25 1979, that (I) (we) lost saw the deceased alive on 11/25/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
								11/26/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
F. M. THOMAS				V M H							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial				11/30/1979		Balto. Nat. Cemetery		Baltimore Co., Maryland			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS Wm. C. March F/H 1101 East North Avenue						NOV 28 1979		[Signature]			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.				
1- STATE REGISTRAR										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										7 9 27168				
1. DECEASED NAME (TYPE OR PRINT)					FIRST COREY					MIDDLE BROWN					LAST BROWN					2a. DATE KNOWN OF DEATH		2b. HOUR		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR		2e. MIN		2f. SEC						
male		negro		9 30 79		1 YRS. 14		1 MONTHS 14		HOURS		11 15 19 79		12:44		P M								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland					U.S.A.										Baltimore City					MD.				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore					St. Agnes Hospital (DOA)																			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																								
13a. STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS				
Maryland										Baltimore					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					208 S. London Ave				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.					17. INFORMANT				
Jeffrey					Brown					Delores					Clay									
16a. YES, NO, OR UNKNOWN					16b. IF YES, GIVE WAR OR DATES															Gwendolyn Clay 208 S. London Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I DEATH WAS CAUSED BY:										Sudden Infant Death Syndrome														
7980 IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b)														
										DUE TO, OR AS A CONSEQUENCE OF														
										(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															20. AUTOPSY?				
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)														
					P.M. 19																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION														
										STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:										Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE					TITLE (SPECIFY)										DATE SIGNED									
Thomas D. Smith					Deputy Chief										11-16-79									
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS																			
Thomas D. Smith, M.D.					111 Penn St.																			
23a. BURIAL, CREMATION, REMOVAL					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION									
BURIAL										Westview Cemetery					Baltimore, Maryland									
24. FUNERAL DIRECTOR					ADDRESS										25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
William Brown					1206 W. North Ave										NOV 23 1979					[Signature]				

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST.,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR  
 STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>George E. Brown</i>						2a. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 11-8 19 79		2b. HOUR M <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11-1-27</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>51</i> YRS.	IF UNDER 1 YR. MONTHS DAYS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <i>11-8 19 79</i>		7d. HOUR M <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.			
10. CITY OR TOWN OF DEATH <i>Lanham</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Doctors' Hosp. of Pr. Geo. Co.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Driver</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Truck</i>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>MD</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Hyattsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1815 Willendale Pl.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henny Brown</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Allen</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>None</i>		17. INFORMANT <i>Annie Brown</i>		ADDRESS <i>Saints 13E</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myotonic Dystrophy</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>cardiac</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>disease</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Dr. P. P. P. P.</i>		MEDICAL EXAMINER <i>Dr. P. P. P. P.</i>		DATE SIGNED <i>11-8-79</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>Dr. P. P. P. P.</i>		ADDRESS <i>3009 Rayburn Court Camp Springs</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>11-10-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Highland Park MD</i>			
24. FUNERAL DIRECTOR NAME <i>H.S. Washington &amp; Sons</i>		ADDRESS <i>4925</i>		25. DATE REC'D. BY REGISTRAR <i>NOV 14 1979</i>		26. REGISTRAR'S SIGNATURE <i>Henry McHenry</i>			

MEDICAL CERTIFICATION



NOV 1 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 1 7 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HARRIETT C. BROWN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 22, 1979</b>		2b. HOUR <b>12:34 A.</b>	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 27 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Brown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Omelia Cottman</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-07-6447</b>		17. INFORMANT ADDRESS <b>Herbert Naylor 2579 Kirk Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>4519</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Possible pulmonary embolus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Possible thrombophlebitis</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Rheumatoid arthritis, pulmonary fibrosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 21</b> 19 <b>79</b> , to <b>Nov. 22</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>Nov 22</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Nancy Peters M.D.</b>				DEGREE		22c. DATE SIGNED <b>11/22/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Nancy L. Peters M.D.</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/28/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Nat. Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 East North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Dixie McLeod</b>	

EVER 8 S VOW

7-2-1942



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

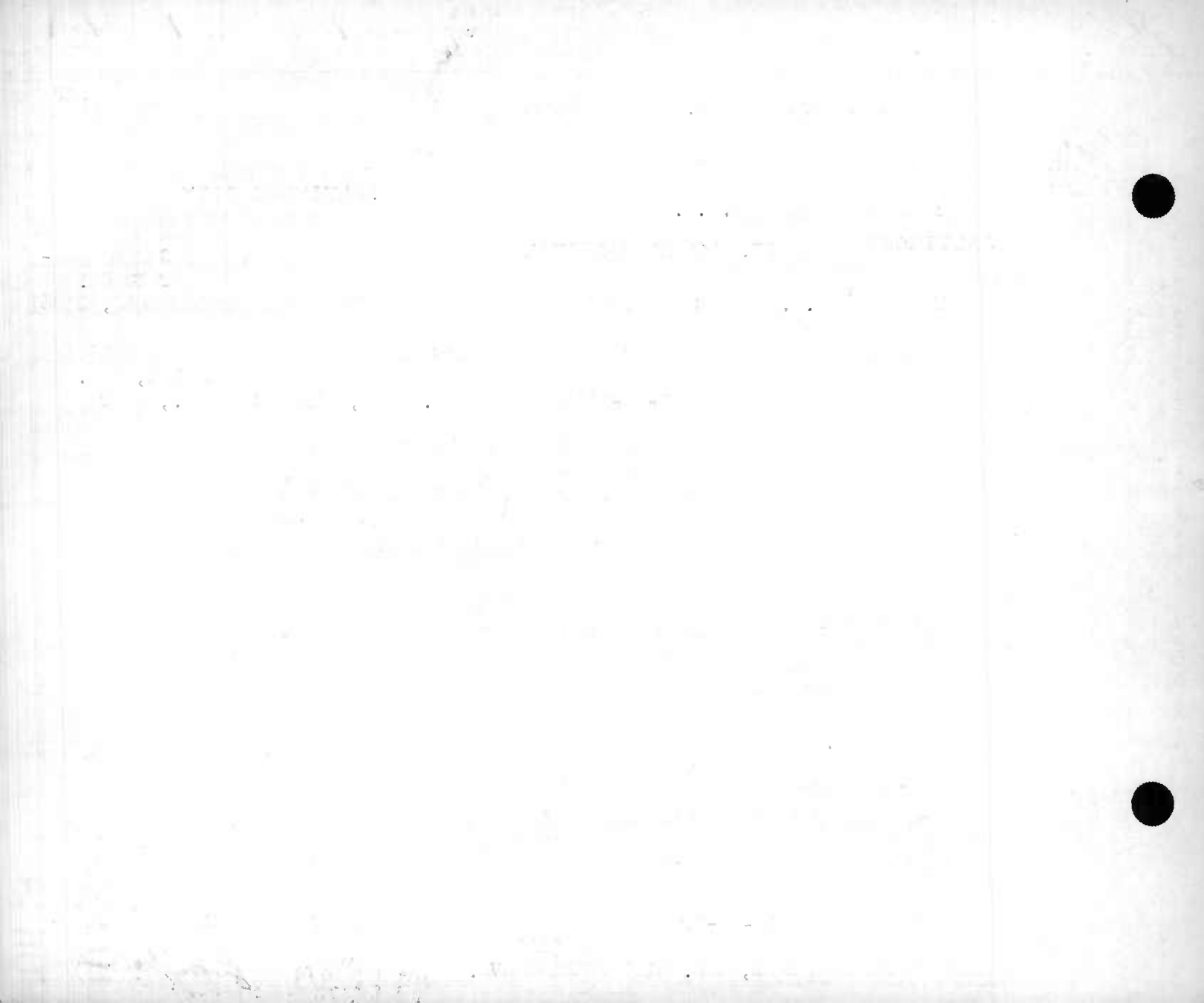
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 7 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JEANETTE M. BROWN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 10 79</b>		2b. HOUR <b>11:50 P.M.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>04 01 13</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	8b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
11. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESPERSON</b>	13b. KIND OF BUSINESS OR INDUSTRY <b>GAS &amp; ELEC-</b>	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE 14b. COUNTY 14c. CITY OR TOWN <b>MARYLAND A.A. GLEN BURNIE</b>			15. STREET ADDRESS <b>TRIC CO. 901 OLD ANNAPOLIS ROAD, 21061</b>		
16a. FATHER'S NAME FIRST MIDDLE LAST <b>MALCOLM GEORGE</b>		16b. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VIRGINIA HARRISON</b>			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		17b. SOCIAL SECURITY NO. <b>213-18-3664</b>		17c. ADDRESS <b>LESLIE A. BONN, 515 CITRUS CL., EAST PALM BAY, FLA.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Cardiac failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of caecum &amp; diffuse metastases to ascites</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hepatic &amp; intra abdominal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>10/29/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Jaundice &amp; abdominal pain</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/19</b> 19 <b>79</b> to <b>11/10</b> 19 <b>79</b> , that my (we) last saw the deceased alive on <b>11/10</b> 19 <b>79</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>I</del> (we) did <del>not</del> view the body after death.					
22b. SIGNATURE <b>Seema Ansan Khan</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/10/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SEEMA ANSAN KHAN</b>		22e. ADDRESS <b>St Agnes Hospital, Dept of Surgery</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>11-14-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) <b>Manuel Brown</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 1, 1979</b>		2b. HOUR <b>11:30 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 6, 1888</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS MIN. <b>91</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>527 Allendale Street</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stewart Brown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emily Moore</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Steel Worker</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-013728A</b>		17. INFORMANT ADDRESS <b>Manuel L. Brown/527 Allendale St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Gangrene @ leg</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R. Imam</b>		DEGREE		22c. DATE SIGNED <b>November 5, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ASIF IMAM</b>		22e. ADDRESS <b>900 CATON AVE, BALTIMORE</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/07/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>	
24. FUNERAL DIRECTOR NAME <b>Marshall w. Jones, Jr.</b>		24b. ADDRESS <b>4101 Edmondson Ave.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus Balto. Md.</b>	
25a. DATE REC'D. BY REGISTRAR <b>NOV 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia Helms</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

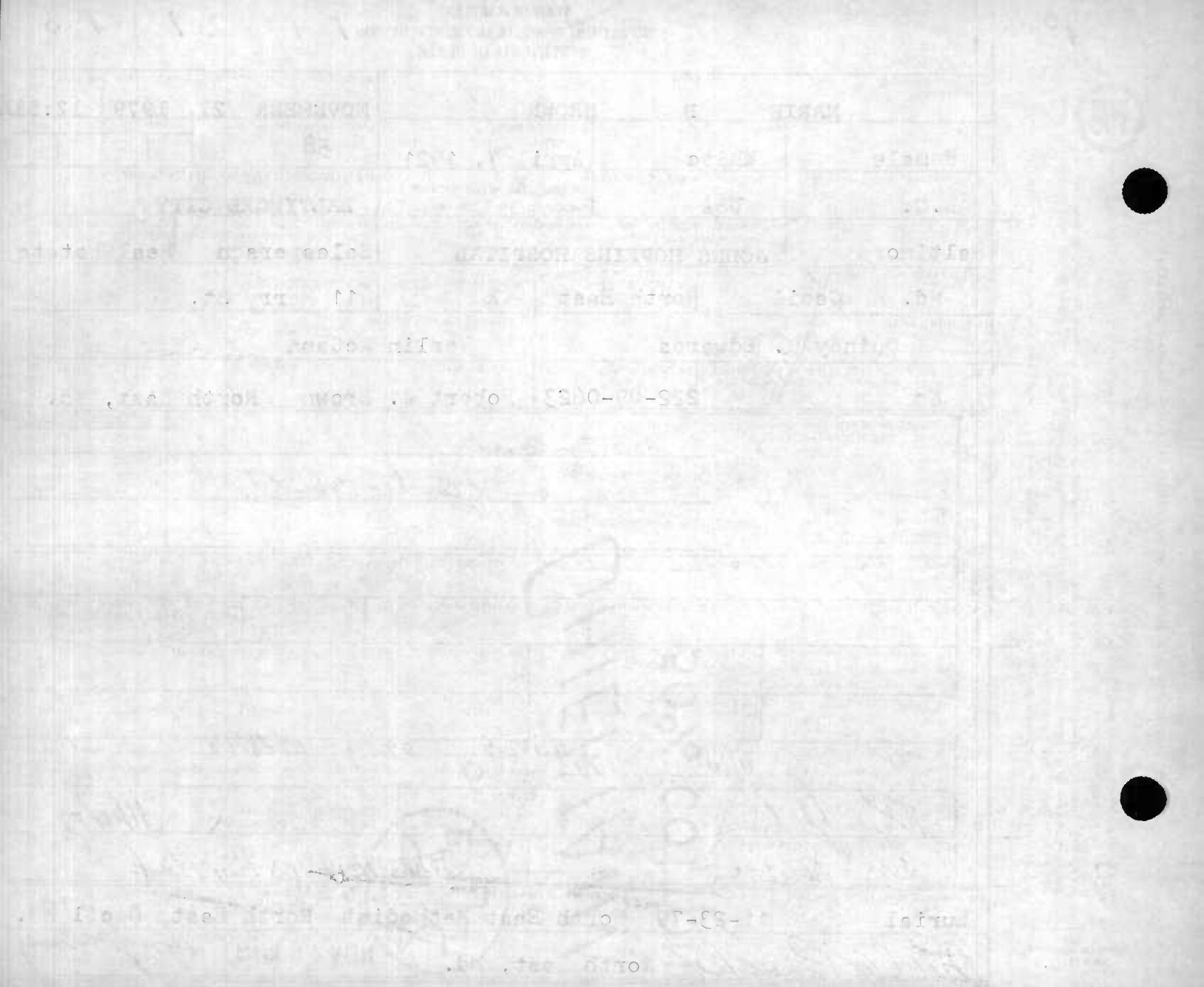
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIE B BROWN			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 21 1979			2b. HOUR 12:50A				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 7. 1921		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Real Estate		
13a. STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 411 Merry St.	
14. FATHER'S NAME FIRST MIDDLE LAST Quincy G. Edwards				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Verlin McCann						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 222-09-0623		17. INFORMANT ADDRESS Robert J. Brown North East, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 1590 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of Bowel - Metastatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/14/79</u> , 19 <u>79</u> , to <u>11/21/79</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/20</u> , 19 <u>79</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
21f. SIGNATURE <u>Ross Jacobson</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 11/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ross Jacobson			22e. ADDRESS Johns Hopkins Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-23-79		23c. NAME OF CEMETERY OR CREMATORY North East Methodist			23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.		
24. FUNERAL DIRECTOR <u>Bulk R. Rouch</u>			ADDRESS North East, Md.			25a. DATE REC'D. BY REGISTRAR NOV 26 1979			25b. REGISTRAR'S SIGNATURE <u>Wm J. McCreedy</u>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 5 See phone with Funeral Home

11/20/79 gj

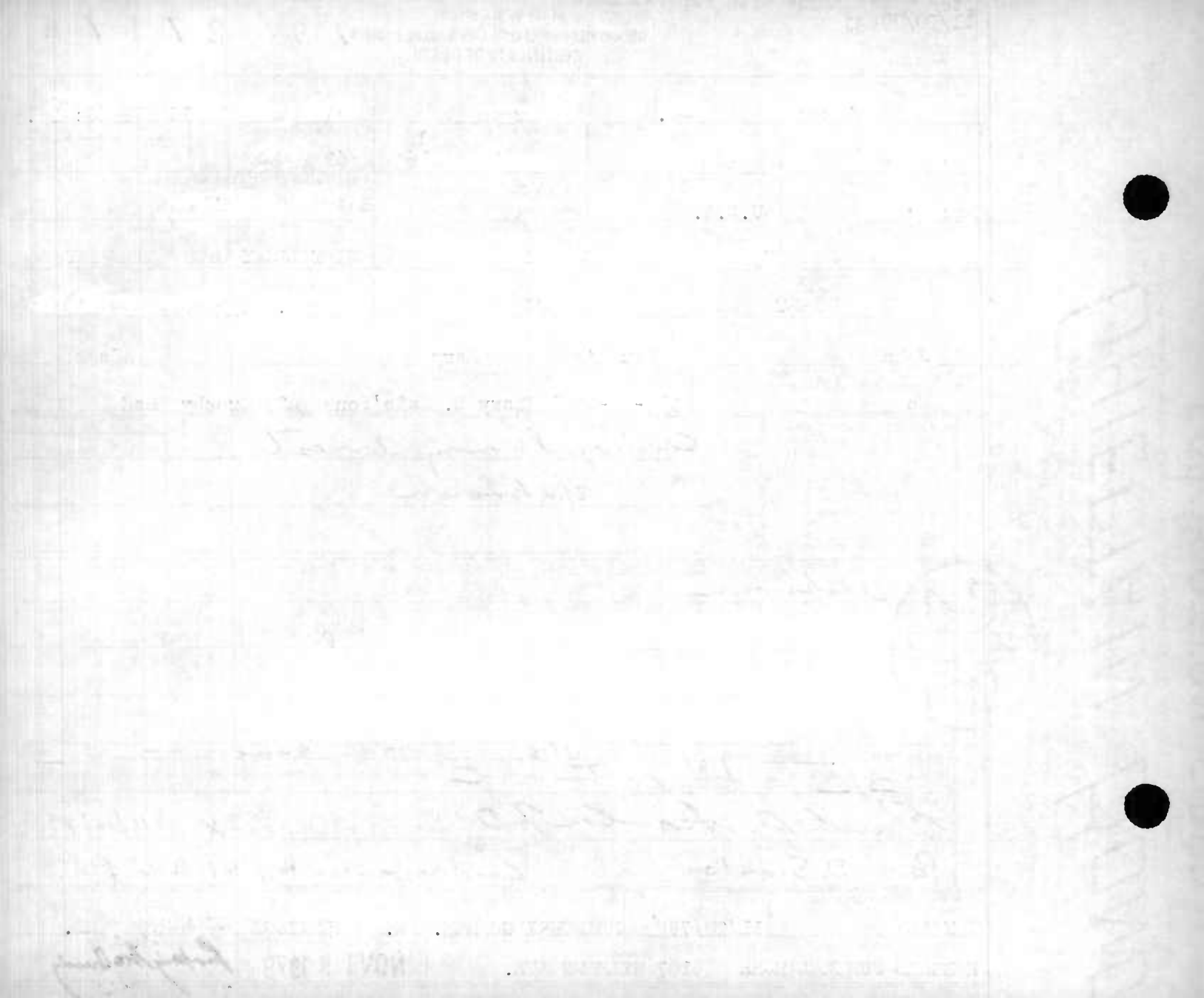
1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Victor L. Bryan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 16 79</b>		2b. HOUR <b>7:43 P.M.</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 21 15</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>63</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DISTILLERY OPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BREWERY</b>				
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>ELLICOTT CITY</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Baublis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Adams</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-05-2201</b>		17. INFORMANT <b>Mary L. Sala'Pong</b> ADDRESS <b>420 Crosby Road</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Unknown</b>						
19a. DATE OF OPERATION <b>11/16</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>19</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11/16</b> , 19 <b>79</b> , to <b>Same</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/16</b> , 19 <b>79</b> , and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <b>Paul D. Scanlon</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/16/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul D. Scanlon</b>		22e. ADDRESS <b>Good Samaritan Hospital Balto Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/20/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PK.</b>		
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME</b>		ADDRESS <b>4107 WILKENS AVE.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELK RIDGE HOWARD MD.</b>		
25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>				







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 7 5

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Alphonzo P. Bryant</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 24 79</i>			2b. HOUR <i>1:00 PM</i>			
3 SEX <i>Male</i>		4 RACE <i>Negro</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>8 12 1918</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Bryant</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary</i>			16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes</i>			
16b. SOCIAL SECURITY NO. <i>241-12-6799</i>			17 INFORMANT ADDRESS <i>Virginia Bryant 2219 Ruskin Avenue</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardiovascular disease</i> <i>4029</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>RIO Subdural hematoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>POK TING Hsiao on 11/24/79</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>None</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/24</i> , 19 <i>79</i> , to <i>11/24</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/24</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>H. Nager, M.D.</i>			DEGREE			22c. DATE SIGNED <i>11/24/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HUSAM M. NAGER</i>			22e. ADDRESS <i>Provident Hospital Balt MD 21215</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>11/30/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King Memorial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Co., Maryland</i>		
24 FUNERAL DIRECTOR NAME <i>Wm. C. March F/H</i>			ADDRESS <i>1101 East North Avenue</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 27 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Fitzroy McReddy</i>	

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

01113 1-1-1941

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 7 6

REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <i>Horace Bryant</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-13-79</i>		
3. SEX <i>M</i>	4. RACE <i>Blk</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11-4-79</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>17</i>		7b. HOUR <i>1:35 PM</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>city</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University Maryland</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md</i> 13b. COUNTY <i>Balt</i> 13c. CITY OR TOWN <i>Balt</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <i>2451 Callow ave apt 1</i>		
14. FATHER'S NAME <i>Horace Bryant SR.</i>			15. MOTHER'S MAIDEN NAME <i>Virginia Eaton</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: <i>7465</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>h.v. failure</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Open heart surgery</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary arterial stenosis; P.D.A. V.S.D.</i>		

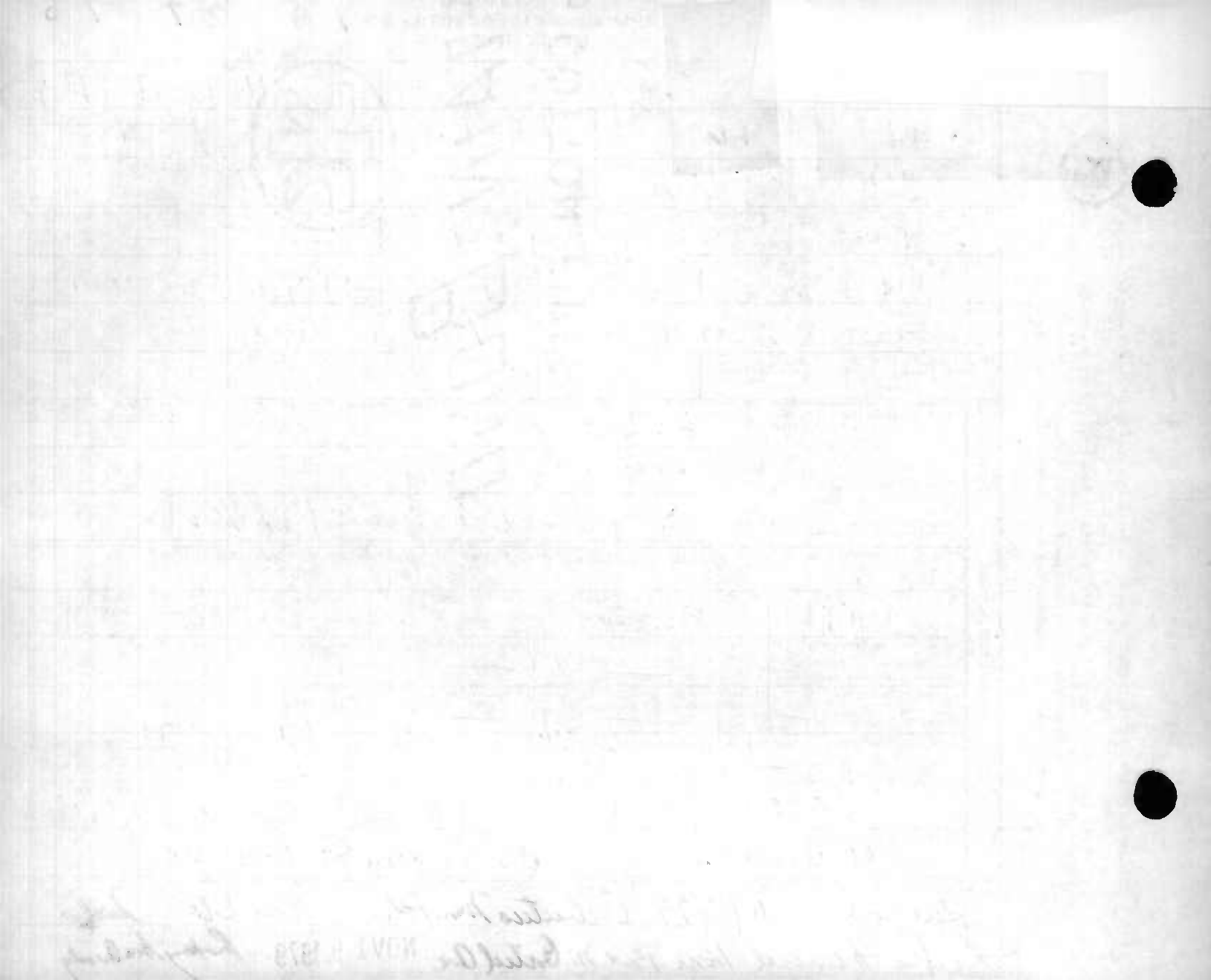
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION <i>11/13/79</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>B.C. above</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>11/13 79</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>11/13</i> 19 <i>79</i> to <i>11/13</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/13</i> 19 <i>79</i> and that in (my) (our) opinion death occurred in the date and hour and from the causes stated above, (I) (we) (ord) (did not) view the body after death.			
22b. SIGNATURE <i>W. W. Schenk</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>11/15/79</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. W. Schenk</i>	22e. ADDRESS <i>307 S. Green St. Balt Md</i>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>11/17/79</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mm. Pk.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balt Md</i>
24. FUNERAL DIRECTOR NAME <i>Lorke Funeral Home</i>	ADDRESS <i>1606 1309 N. Central Ave</i>	25a. DATE REC'D. BY REGISTRAR <i>NOV 19 1979</i>	25b. REGISTRAR'S SIGNATURE <i>Robert M. Harty</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be enclosed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 1 7 7				
FOR 1 - STATE REGISTRAR				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>LYDA G. BRYANT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 16 1979</b>			2b. HOUR <b>10:30 PM</b>		
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 15 1916</b>		6 AGE [IN YEARS (LAST BIRTHDAY)] <b>63</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1709 North Washington Street</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>John A. Graham</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Graham</b>					
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS <b>James Bryant 1709 North Washington Street</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic Shock</b> <b>2050</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>aplasia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>acute myelogenous leukemia &amp; chemotherapy</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 days</b> <b>1 week</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>October 3</b> , 19 <b>79</b> , to <b>November 16</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>November 16</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Stephen Wank</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/16/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen Wank</b>				22e. ADDRESS <b>801 N Broadway, Baltimore, MD, 21205</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/21/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24 FUNERAL DIRECTOR NAME <b>W.C. March FH.</b>				ADDRESS <b>1101 E. North Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		

NOVEMBER 16 1957  
BOSTON  
MASS



TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and illegible, appearing to be a series of lines or a list.]

OC-25 S 13-1-15-84

NOV 16 1957

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 27 178

FOR  
1. STATE  
REGISTRAR

REG. NO.

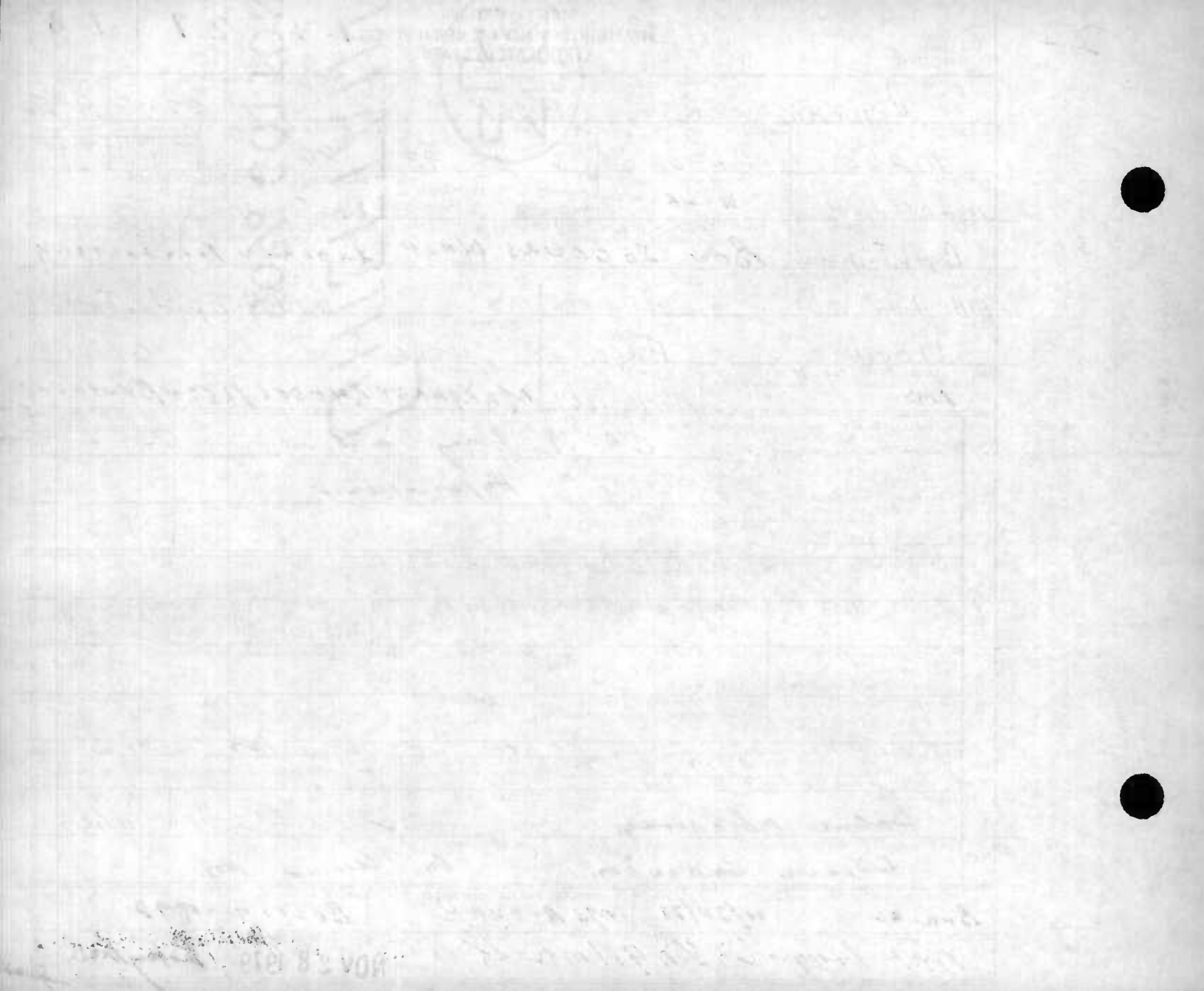
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William R. BUCK			2a. DATE OF DEATH MONTH DAY YEAR 11 27 79		2b. HOUR 9:33 AM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 6 05 93		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LASON TUB FACTORY		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13e. STREET ADDRESS 619 N. Appleton ST	
14. FATHER'S NAME FIRST MIDDLE LAST Lloyd BUCK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Gross			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-10-9869		17. INFORMANT ADDRESS MARGARET RHODES 1257 N. BENTLEY	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA 2 Lung with 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypercalcemia DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/18, 1979, to 11/27, 1979, that (I) (we) lost saw the deceased alive on 11/27, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					22c. DATE SIGNED 11/28/79
22b. SIGNATURE Roderick S. Brown		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roderick S. Brown		22e. ADDRESS On New York Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/30/79	23c. NAME OF CEMETERY OR CREMATORY Mt Auburn		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME Mr P. Hays 638 N. 9th St		25a. DATE REC'D. BY REGISTRAR NOV 28 1979		25b. REGISTRAR'S SIGNATURE Roderick S. Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove car bon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.









STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 7 1 7 9			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
THERESA BUCKNER				NOV 8 1979 9 45 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		12-12-00		78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTO. MD		U.S.A.				BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		2705 W. GARRISON AVE.		HOUSEWIFE		AT HOME	
13a. STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
MAX NEISTADT				REBECCA COHEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				216-03-4249B		MR. EMANUEL BUCKNER 2705 W. GARRISON AVE. #21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) HEART FAILURE.							15 min
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR							8 YRS
DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
NA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
N/A		N/A		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19		N/A			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
		N/A		N/A			
22a. I certify that (I) (this hospital) attended the deceased from DEC 11-8-19 79, to 11-8-19 79, that (I) (we) last saw the deceased alive on 11-8-19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Bernard S. Karpers Jr. M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/7/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
BERNARD S. KARPERS JR. M.D.				513 MEDICAL ARTS BLDG. BALTO. MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		11-9-79		ALINGTON-CHIZUK AMINO		BALTIMORE MD	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215				NOV 14 1979		[Signature]	

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300  
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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director and completely filled in by the funeral director. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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P 1

RECEIVED  
JAN 1 1961

1

RECEIVED  
JAN 1 1961

100-1-1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMHM-17  
(VR A15 ME (5))  
30M 7/73

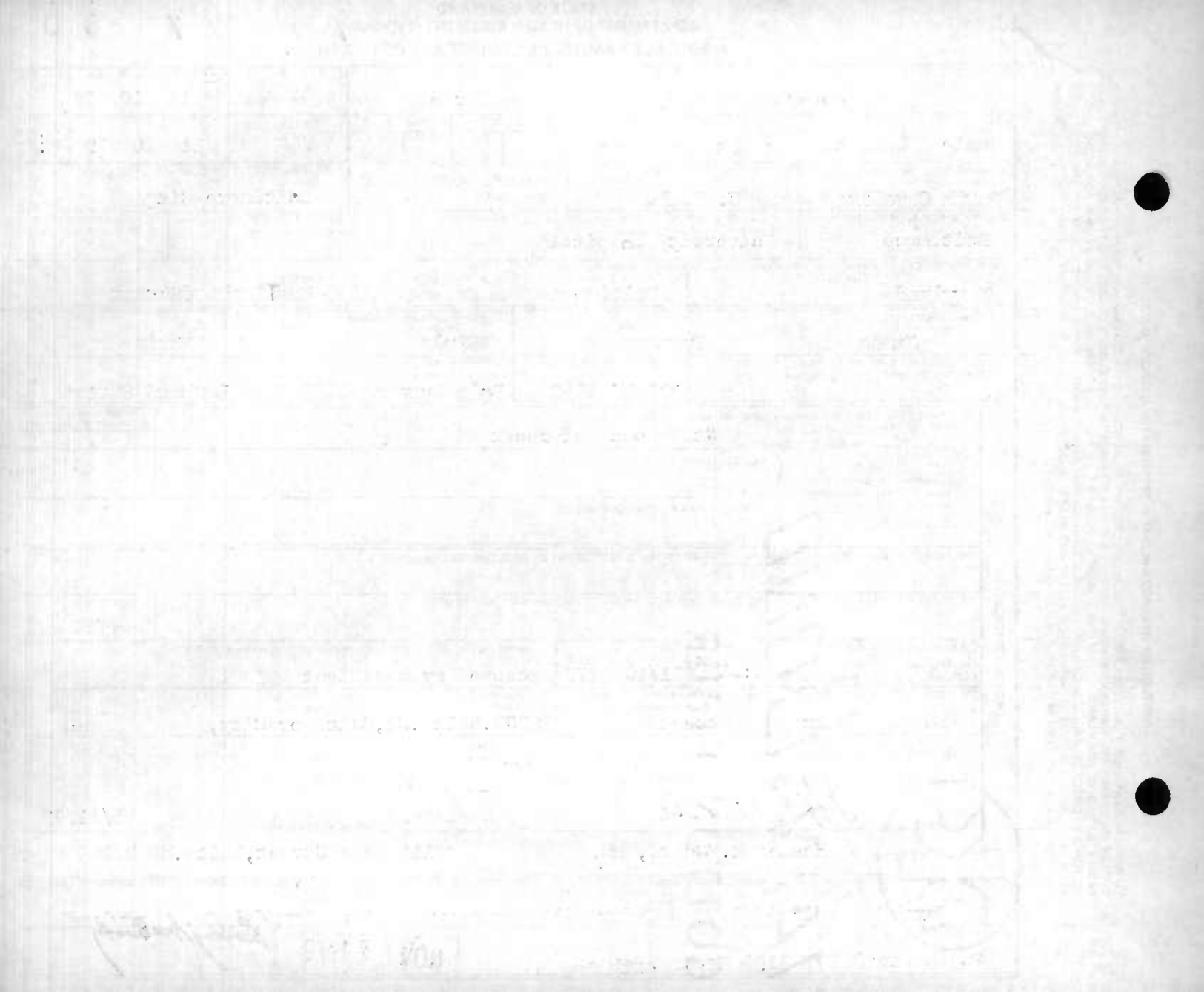
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph E. Burgess</b>			2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>11 10 79</b>			2b. HOUR M <b>2:05 P.</b>			
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 15 1940</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>39 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 10 1979</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1109 West Lombard Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Burgess</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula Martin</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-36-1778</b>		17. INFORMANT ADDRESS <b>Lula Burgess 1109 West Lombard Street</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stab wound of chest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>1:11 P.M. 11/10 1979</b>			21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>1:11 P.M. 11/10 1979</b>						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>stabbed by assailant</b>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1020 W. Balto. St, Baltimore City, MD</b>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <b>H.R. Guard</b>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>11/11/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, MD.</b>			ADDRESS <b>111 Penn Street, Balto. MD 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/16/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

1803





FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

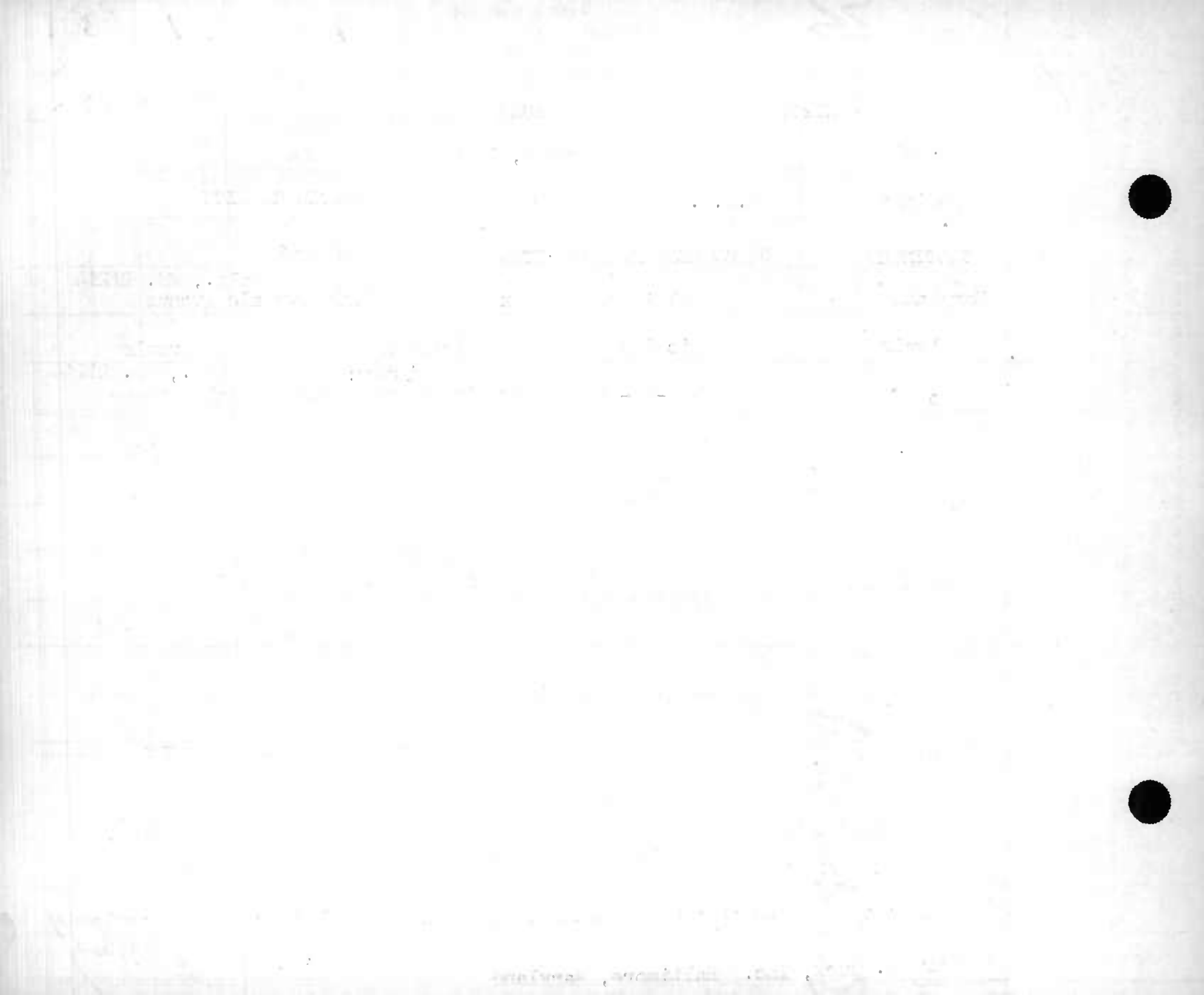
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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILMA C BURK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 7 79</b>			2b. HOUR <b>1815</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 4, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Balt., Md. 21214 3208 Tyndale Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Nichter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Greule</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>304-09-8065</b>		17. INFORMANT <b>Sister:</b>		ADDRESS <b>Balt., Md. 21214 Loretta Huston 3208 Tyndale Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cachexia</b> <b>438-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>old CVA, debility</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Old myocardial infarction, Hx of congestive heart failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <b>11/7</b> , 19 <b>79</b> , to <b>11/7</b> , 19 <b>79</b> , that (b) (we) lost saw the deceased alive on <b>11/7</b> , 19 <b>79</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Frank R. Claudy MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>11/8/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frank R. Claudy</b>				22e. ADDRESS <b>Union Memorial Hosp.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 11 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Ruck</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 2 7 1 8 2	
1. FOR STATE REGISTRAR			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HARRY A. BURKE SR.			2a. DATE OF DEATH MONTH DAY YEAR 11-5-79		2b. HOUR 6:20 PM	
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11-22-1891	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIREMAN		12b. KIND OF BUSINESS OR INDUSTRY FIRE DEPT.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN ARBUTUS			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 196 OAKLEE VILLAGE, 21229	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD J. BURKE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE C. UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW I 220-44-0252	17. INFORMANT ODENVILLE ADDRESS ALABAMA VIRGINIA B. HEZLEP, RT. 1 BOX 97 A 5			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION + EDEMA 4409 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTROPHY OF THE MYOCARDIUM DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CIRRHOSIS OF THE LIVER						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Michael E. Pelczar		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/5/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. PELCZAR MD.		22e. ADDRESS 900 CATON AVE BALTIMORE MD 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-08-79		23c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVET		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR NOV 7 1979		

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UNITED STATES

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

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UNITED STATES DEPARTMENT OF JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 1 8 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <del>BURLEY</del> LINDA M. A. BURLEY		2a. DATE OF DEATH MONTH DAY YEAR NOV 4 79		2b. HOUR 8:00 PM	
3. SEX F		4. RACE N		5. DATE OF BIRTH MONTH DAY YEAR 2 16 65		6. AGE (IN YEARS LAST BIRTHDAY) 14 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MT. WASHINGTON PED HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BALTO				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3015 MENDAMUN AV	
14. FATHER'S NAME FIRST MIDDLE LAST Lamont Burley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE Tilley (Burley)		17. INFORMANT ADDRESS MARY Dutton 2204 Aiken Street			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MARY Dutton 2204 Aiken Street			
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 9108 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ANOXIC BRAIN DAMAGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>NEAR DROWNING</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 2 mon 2 mon	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 1 19 79</u> to <u>NOV 4 19 79</u> , that (I) (we) last saw the deceased alive on <u>NOV 4 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Paul Borgan, MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/4/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL BORGAN		22e. ADDRESS MT. WASHINGTON PED HOSP 1705 W. ROGERS AVE BALTO 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/ 9/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Maryland	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Avenue				25a. DATE REC'D BY REGISTRAR NOV 6 1979		25b. REGISTRAR'S SIGNATURE L. J. McCreedy	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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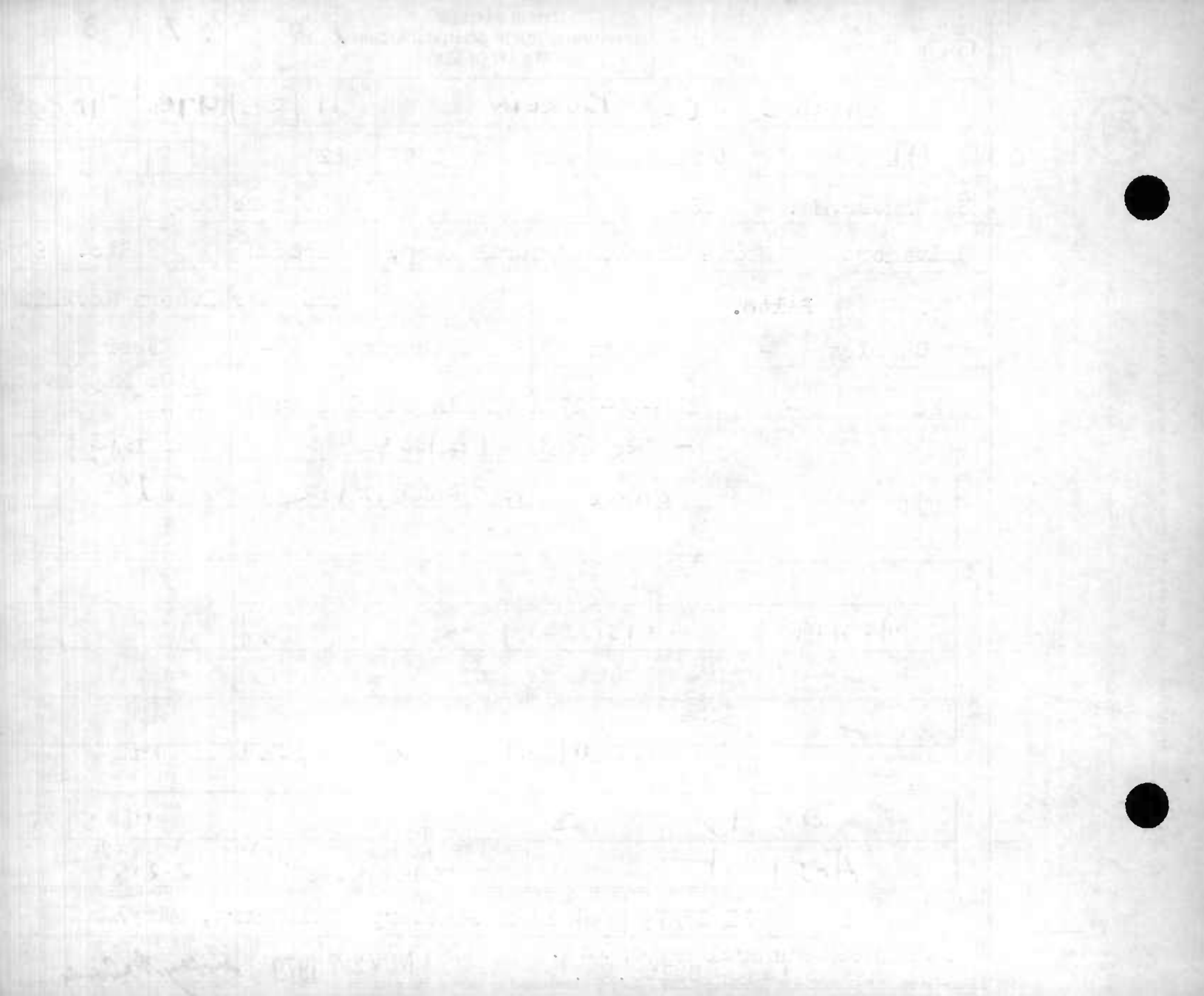
1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES E. BURLIN			2a. DATE OF DEATH MONTH DAY YEAR 11/25/1979			2b. HOUR 10:55 P.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct 5 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hosp,				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fireman		12b. KIND OF BUSINESS OR INDUSTRY Balto. City	
13a. STATE Maryland				13b. COUNTY Balto.		13c. CITY Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Charles - Burlin				15. MOTHER'S MAIDEN NAME Catherine - Ferris					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. - 212-20-3239A		17. INFORMANT Edwin Charles Burlin		ADDRESS 3406 Ripple Rd 21207			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) - Renal Failure 185- DUE TO, OR AS A CONSEQUENCE OF (b) - CANCER OF PROSTATE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - DAYS - YRS.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 11/23/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - Cystoscopy				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/20/1979 to 11/25/1979, that (I) (we) lost saw the deceased alive on 11/25/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE D.R. Angel MD				DEGREE MD				22c. DATE SIGNED 11/25/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANSARIA				22e. ADDRESS North Charles North BALTIMORE, MD 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/27/79		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION Baltimore, Maryland			
24. FUNERAL DIRECTOR Schimunek Funeral Home Inc. 3331 Brehms Lane Balto. Md.				25a. DATE REC'D. BY REGISTRAR NOV 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		7 9 27 185	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST Lucinda Burns		ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11 20 1979	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Female	Black	MONTH DAY YEAR 9 27 06	LAST BIRTHDAY 72 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	U. S. A.		Baltimore City, MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Johns Hopkins Hospital		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT ADDRESS	
FIRST MIDDLE LAST Thomas Thompkin, Sr.	FIRST MIDDLE LAST Sallie Dillard	Ethel Burns 1320 North Chester Street	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED	
<u>Virginia L. Dolan</u>	Assistant	11/21/79	
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS		
Virginia L. Dolan, M.D.	111 Penn Street		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	11/24/79	Baltimore Cemetery	Baltimore, Maryland
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Wm. C. March F/H	1101 East North Avenue	NOV 23 1979	<u>Robert McCreedy</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 8 6

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGARET MARY BURNS			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 3 1979			2b. HOUR 10:30AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 4, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2245 Searles Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST Francis Hartman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline R. Narr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Edawrd J. Burns				ADDRESS Balto. 21225 17th Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, SEPSIS, PNEUMONIA											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 1, 1979, to NOVEMBER 3, 1979, that (I) (we) last saw the deceased alive on NOVEMBER 3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (us) did not view the body after death.											
22b. SIGNATURE ADOLFO LOPEZ						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADOLFO LOPEZ						22e. ADDRESS CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/6/79		23c. NAME OF CEMETERY OR CREMATORY New Cathedral			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME George J. Gonce						ADDRESS Balto 21225 Ritchie Hgwy		25a. DATE REC'D. BY REGISTRAR NOV 6 1979		25b. REGISTRAR'S SIGNATURE R. J. McCreedy	

BP

DHMH-16 20M  
(VRA 15, 4) 7/78





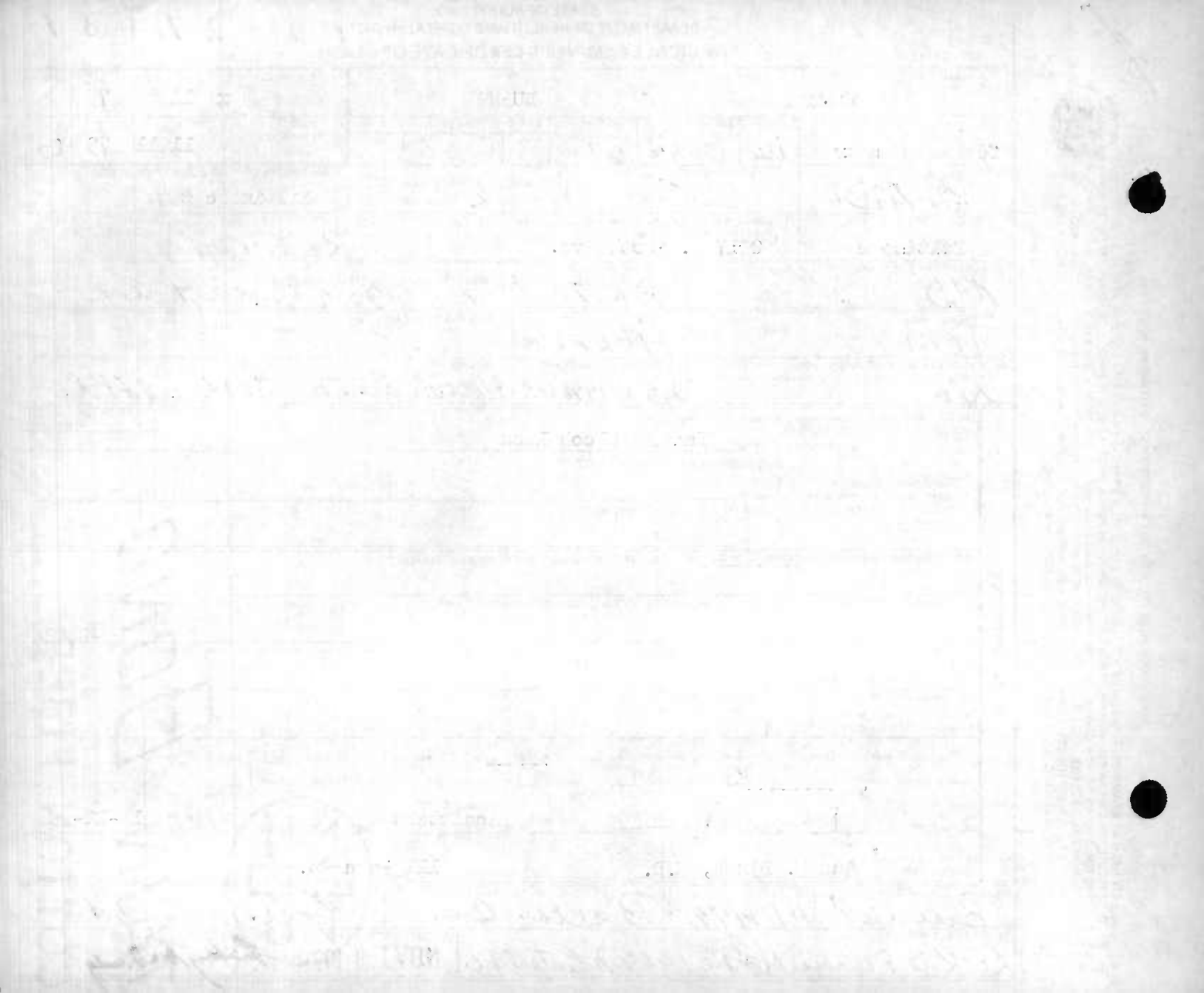
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR RECORDS. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		9 27 187	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST MARTHA BURNS		DATE KNOWN OF DEATH 11 8 1979	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
female	negro	Aug 12 1912	67 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH
Dr. A.D.	U.S.	WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore City MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	2017 E. North Ave.	Retired	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
MD		BALTO	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Tom	Hooper	(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
215-094480A	Howard Burtin	717 Grand Pk. Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic alcoholism 303- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?	
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
M.D. Assistant		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Ann M. Dixon, M.D.		11-12-79	
ADDRESS			
111 Penn St.			
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	11/16/79	Balla. Cem.	Balta. Md.
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Lock 5 Funeral Home	NOV 19 1979	[Signature]	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

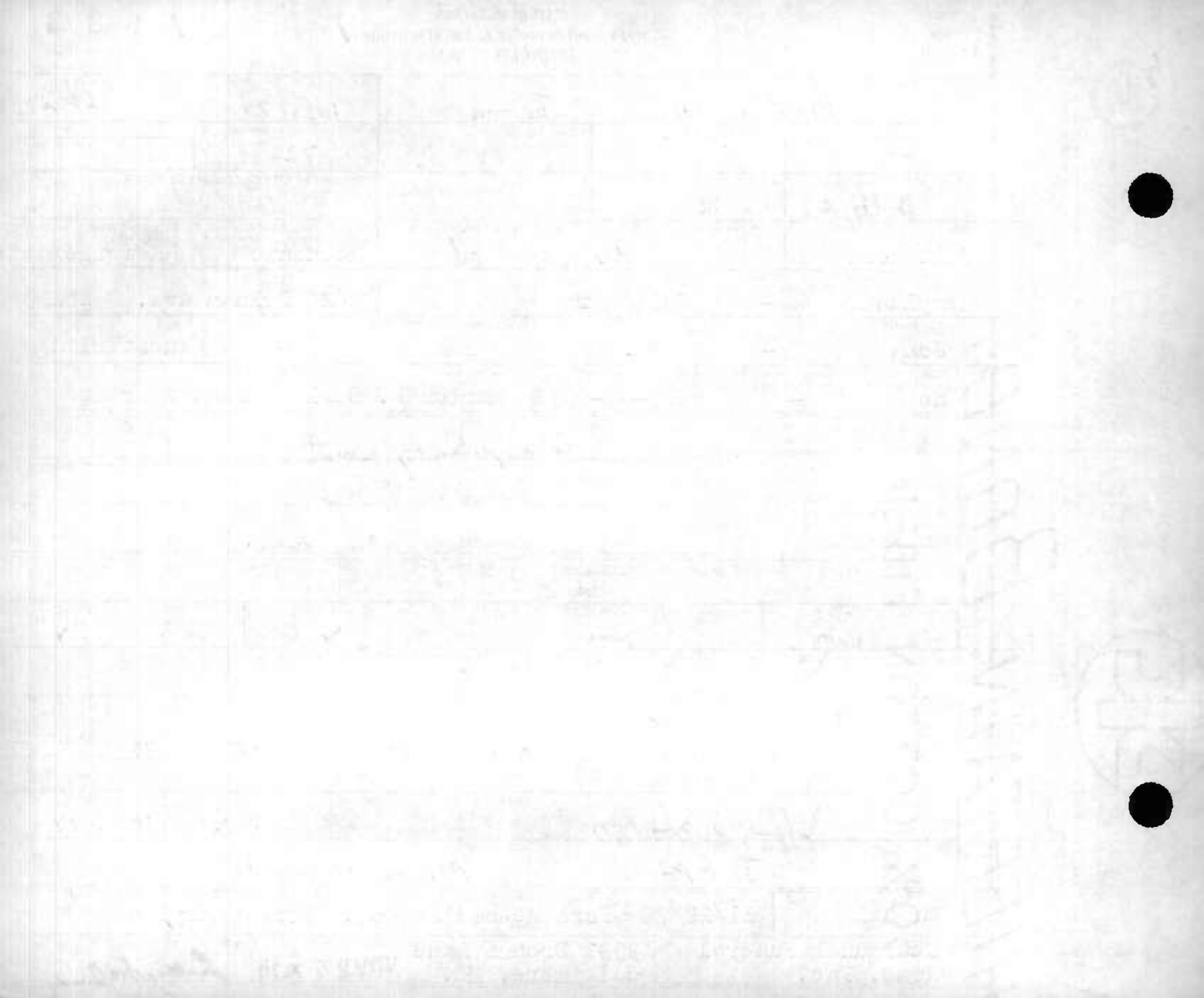
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Austin W. Burton</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>11/25/79</i>			2b. HOUR <i>6:29</i> M		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 18 07</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mary Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Refrigeration</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>					13b. COUNTY <i>-</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John - Burton</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma - Wuesterling</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>215-07-9378</i>		17. INFORMANT <i>Marion F. Berl</i>			ADDRESS <i>same address</i>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Probable V-tach.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>coronary artery disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>NONE</i>										
19a. DATE OF OPERATION <i>NONE</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NONE</i>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>✓</i>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>✓</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>11/18</i> , 19 <i>79</i> , to <i>11/25</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/25</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>J. Gaber</i>				DEGREE <i>MD</i>				22c. DATE SIGNED <i>11-25-79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. GABER</i>				22e. ADDRESS <i>Mary Hospital</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/28/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fork Methodist Cen.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Fork, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Chimunek Funeral Home, Inc.</i>				25. ADDRESS <i>3331 Brehms Lane Baltimore, Md.</i>			26. DATE REC'D. BY REGISTRAR <i>NOV 27 1979</i>		27. REGISTRAR'S SIGNATURE <i>Robert K. B...</i>	

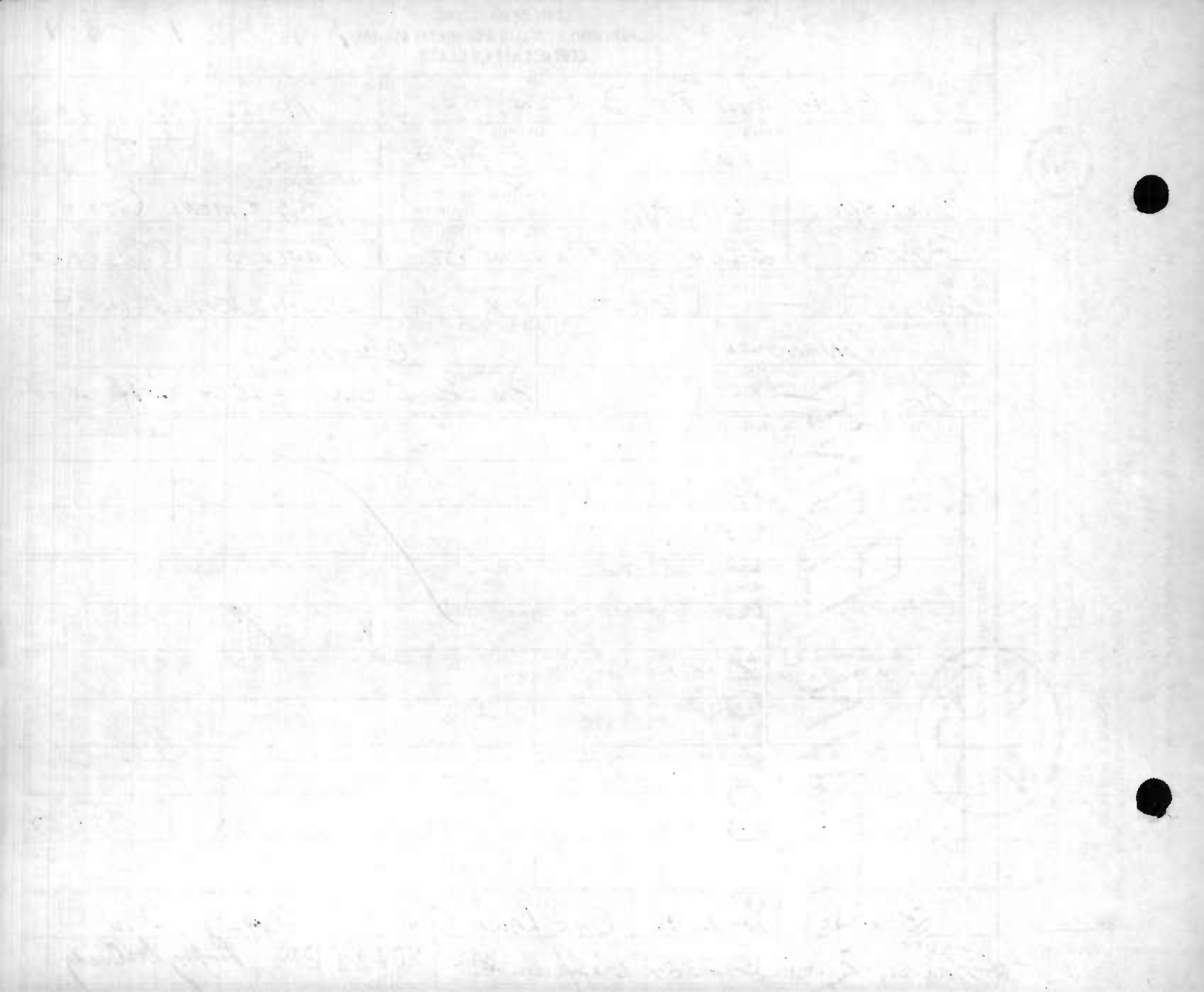


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 2 7 1 8 9				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>BENJAMIN F. BURTON, SR.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-22-79</b>			2b. HOUR <b>3A.</b> M.	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-5-1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2504 JEFFERSON ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2504 JEFFERSON ST.</b>		
13a. STATE <b>MD.</b>		13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>BALTO.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS <b>Mrs. Doris E. Burton - 2504 Jefferson St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1629 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Anemia / Cachexia</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lung Carcinoma, Metastatic</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/13</b> 19 <b>79</b> , to <b>11/17</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/21/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Paula Kinnunen MD</b> DEGREE <b>MD</b>					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>11/23/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAULA KINNUNEN MD.</b>					22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-26-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., MD.</b>			
24. FUNERAL DIRECTOR <b>Charles Miller - 2334 Jefferson St.</b> ADDRESS <b>—</b>					25. DATE REC'D. BY REGISTRAR <b>NOV 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Richard McCready</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PURNELL L. BURTON			2a. DATE OF DEATH MONTH DAY YEAR 11 17 79			2b. HOUR 10 55 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9-10-1913		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital & L			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST John S. Burton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lina Gertrude Reark				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-6836		17. INFORMANT ADDRESS Paul Wilson - 504 Calender St. 21230		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>Myocardial Infarction</del> Ruptured Aortic Aneurysm		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4415 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 17 NOV 19 79, to 17 NOV 19 79, that (I) (we) lost saw the deceased alive on 17 NOV 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
23a. SIGNATURE A. P. Walker MD		23b. DEGREE M.D.	
23c. PHYSICIAN'S NAME (TYPE OR PRINT)		23d. ADDRESS UNIV. OF Maryland Hosp	
23e. DATE SIGNED 17 NOV 79		23f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23g. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried		23h. DATE 11-21-79	
23i. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		23j. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	

24. FUNERAL DIRECTOR NAME John J. Cowan, Sr. Inc. 901 Talbott St.		25a. DATE REC'D. BY REGISTRAR NOV 21 1979		25b. REGISTRAR'S SIGNATURE [Signature]	
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RECEIVED  
FBI NEW YORK

SEP 10 1964





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 9 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

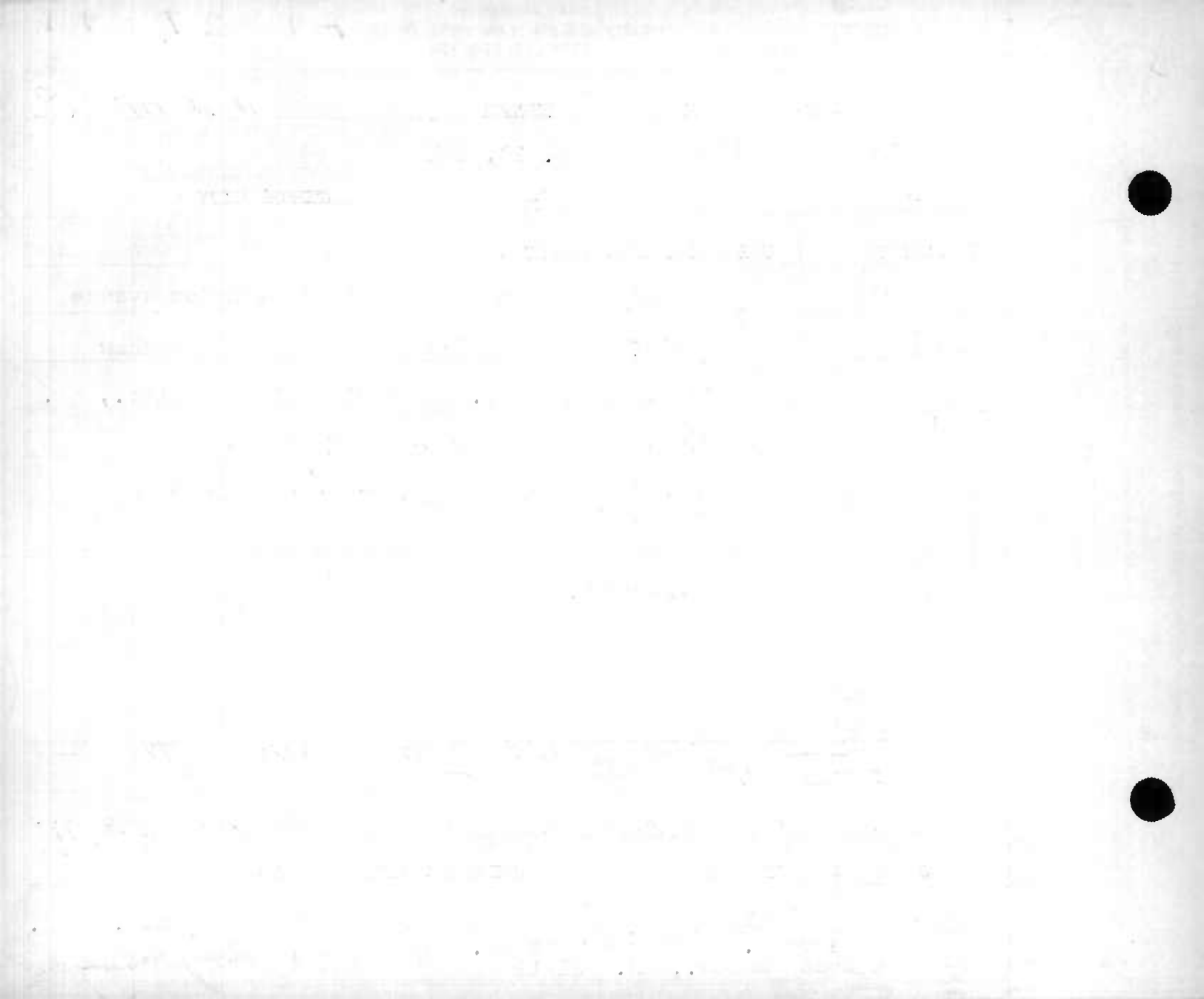
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELVA M BUTLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 20 1979</b>		2b. HOUR <b>12 P.M.</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 23, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>11 20 1979</b>		8. IF UNDER 24 HRS HOURS MIN <b>12 P.M.</b>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
13. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE <b>Maryland</b>		17b. COUNTY <b>Baltimore</b>		17c. CITY OR TOWN <b>Baltimore</b>		17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17e. STREET ADDRESS <b>2616 Huntingdon Avenue</b>			
18. FATHER'S NAME FIRST MIDDLE LAST <b>John Bosley</b>		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Openshaw</b>		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		21. SOCIAL SECURITY NO. <b>220 03 3863</b>		22. INFORMANT <b>Mrs. Marguerite List</b>		23. ADDRESS <b>Balto., Md.</b>	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiogenic shock asystole</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Inferior myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										25. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Two previous infarctions, ADM</b>	
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE			
35. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		37. LOCATION STREET CITY OR TOWN COUNTY STATE		38. I certify that (I) (this hospital) attended the deceased from <b>11/19</b> 19 <b>79</b> , to <b>11/20</b> 19 <b>79</b> , that (I) (last) saw the deceased alive on <b>11/20</b> 19 <b>79</b> , and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above, (I) (last) (did) (did not) view the body after death.					
39. SIGNATURE <b>Joseph D. Antonio M.D.</b>		40. DEGREE <b>M.D.</b>		41. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		42. DATE SIGNED <b>11/20/79</b>					
43. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH DANTONIO MD</b>		44. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>		45. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		46. DATE <b>11/23/79</b>		47. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		48. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Md.</b>	
49. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>		50. ADDRESS <b>4905 York Road Balto., Md. 21212</b>		51. DATE REC'D. BY REGISTRAR <b>NOV 21 1979</b>		52. REGISTRAR'S SIGNATURE <b>Henry W. Jenkins</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 2 7 1 9 2		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST JOSHUA		MIDDLE BUTLER		LAST BUTLER		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 17 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VETERANS ADMINISTRATION MEDICAL CENTER						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2044 E. Preston Street			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Bulter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Thomas									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS VAMC Clinical Records Balto., Md. 21218							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 1550 DUE TO, OR AS A CONSEQUENCE OF (b) <u>DISSEMINATED HEPATOCELLULAR</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 minutes 4 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NA							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT IN WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 2, 1979</u> , to <u>NOVEMBER 3, 1979</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 3, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Daniel J. Woronow</u>		DEGREE PHYSICIAN		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/3/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WORONOW		22e. ADDRESS 3900 Loch Raven Blvd. Balto., Md. 21218									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/8/1979		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Maryland					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Avenue		25a. DATE REC'D. BY REGISTRAR NOV 6 1979		25b. REGISTRAR'S SIGNATURE <u>Dorothy M. Brady</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

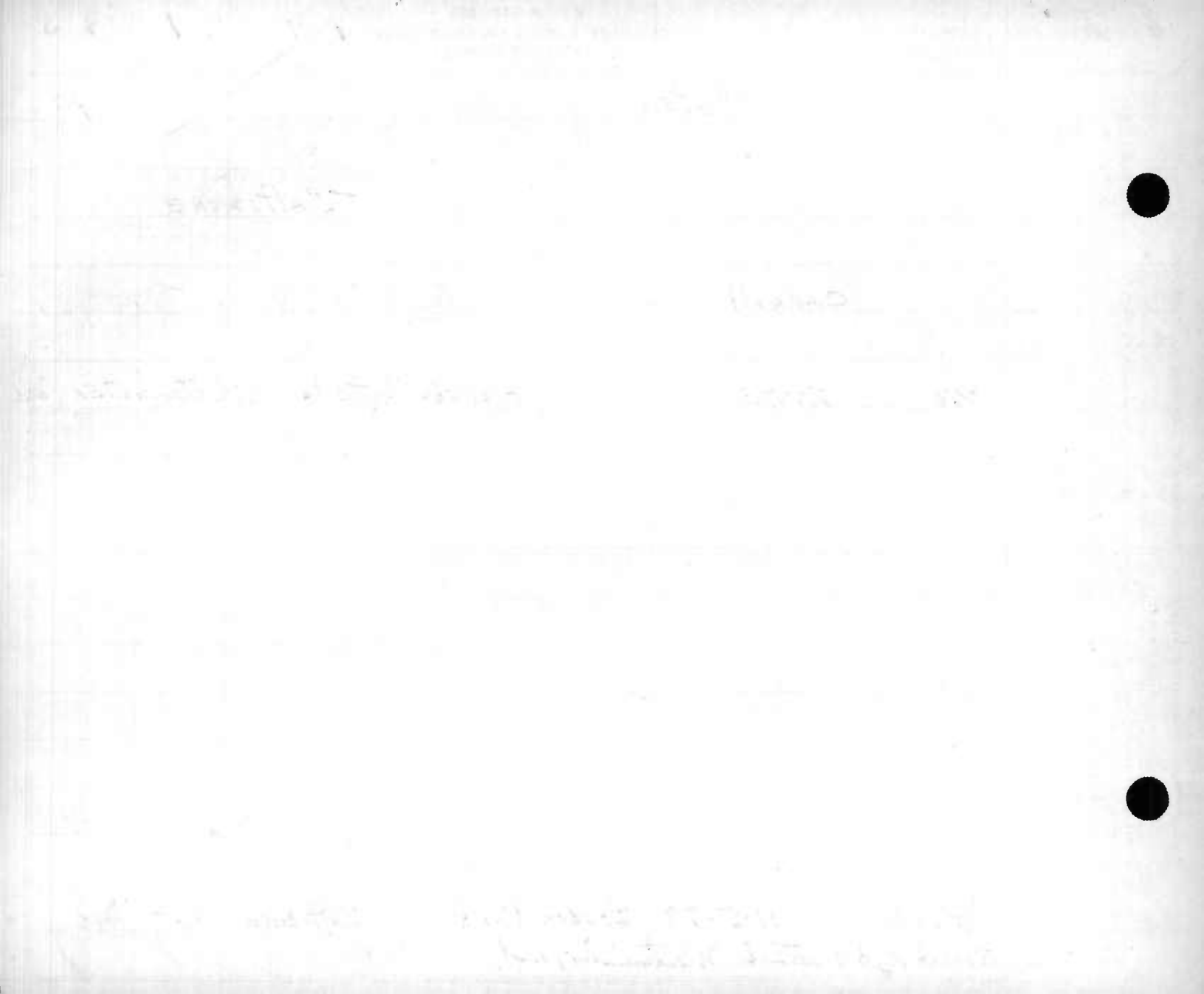
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN PETER BYTELLA			2a. DATE OF DEATH MONTH DAY YEAR 11 1 79			2b. HOUR 11:45 M.					
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Feb 25 1909		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY CARROLL		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1830 Smith Piquet Valley West. MINISTER LAST			
14. FATHER'S NAME FIRST MIDDLE LAST PETER BYTELLA			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KATAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ALFREDA BYTELLA		ADDRESS Westminster, Md				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYELOFIBROSIS. 2898 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. M. F. Maturi MD			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/2/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARU F. MATURI MD			22e. ADDRESS 404 MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11-5-79		23c. NAME OF CEMETERY OR CREMATORY Landon Park		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALT. MD		
24. FUNERAL DIRECTOR NAME Robert Kyle Pritter Jr.			ADDRESS Westminster, Md.			25a. DATE REC'D BY REGISTRAR NOV 7 1979		25b. REGISTRAR'S SIGNATURE	




 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

 FOR  
 1 - STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RUTH G. BYRD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 19 79</b>		2b. HOUR <b>19.35</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 19 74</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>COLUMBIA, S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALT. CITY</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSP OF BALTIMORE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5002 IVANHOE AVE 21212</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH HOFF</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IRENE JACOBS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>248-44-5686</b>		17. INFORMANT ADDRESS <b>MRS. CLYTEE JAMES 3 PHLOX CIRCLE</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1749</b> IMMEDIATE CAUSE (a) <b>METASTATIC CA OF BREAST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

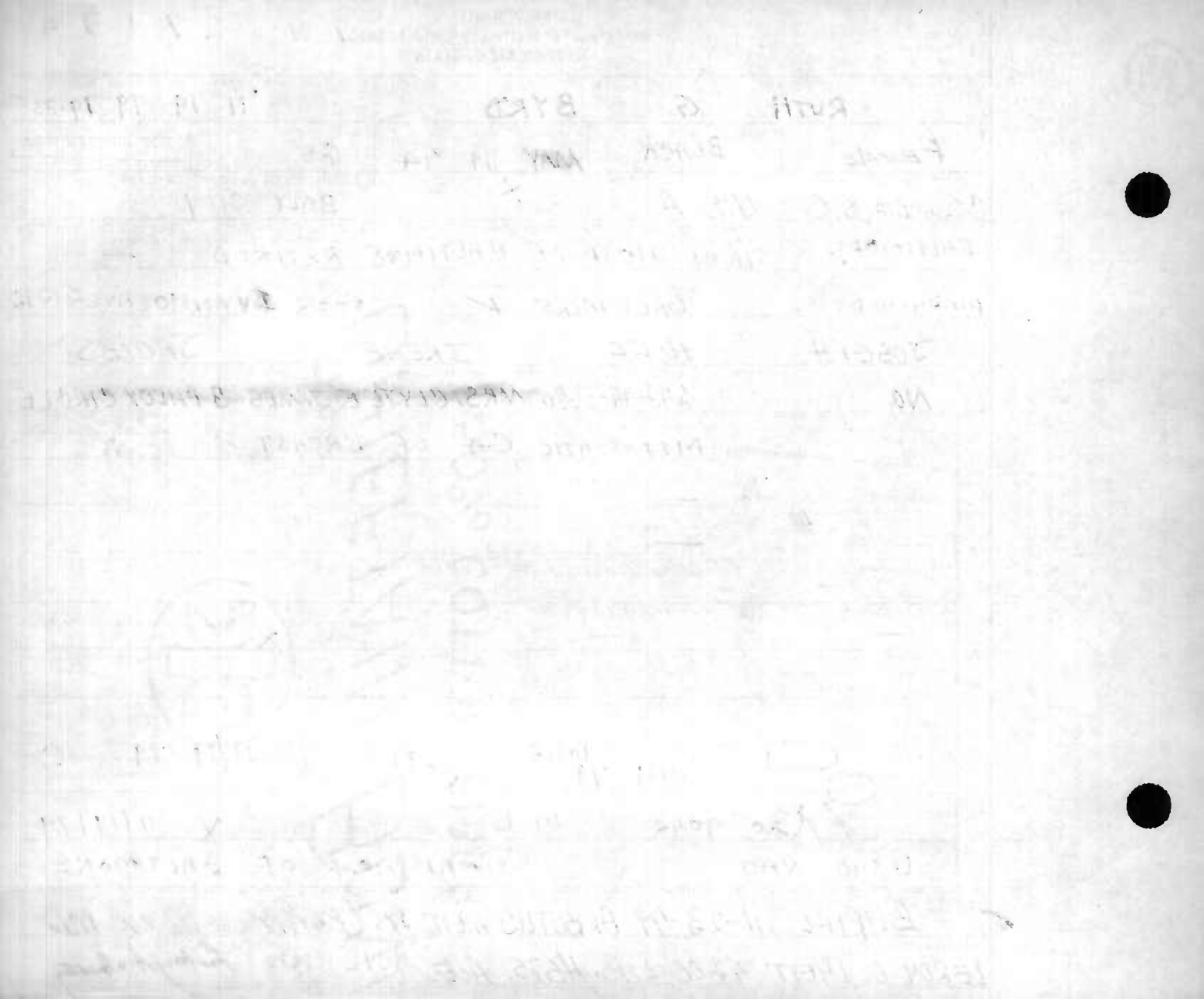
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>—</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <b>10/18 1979</b> to <b>11/19 1979</b> , that (I) we lost saw the deceased alive on <b>11/19 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Usha Rao</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/19/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>USHA RAO</b>				22e. ADDRESS <b>SINAI HOSP OF BALTIMORE.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-23-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANHAM, MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>LEROY O. DYETT 4600 21B. HIGGS AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Brady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

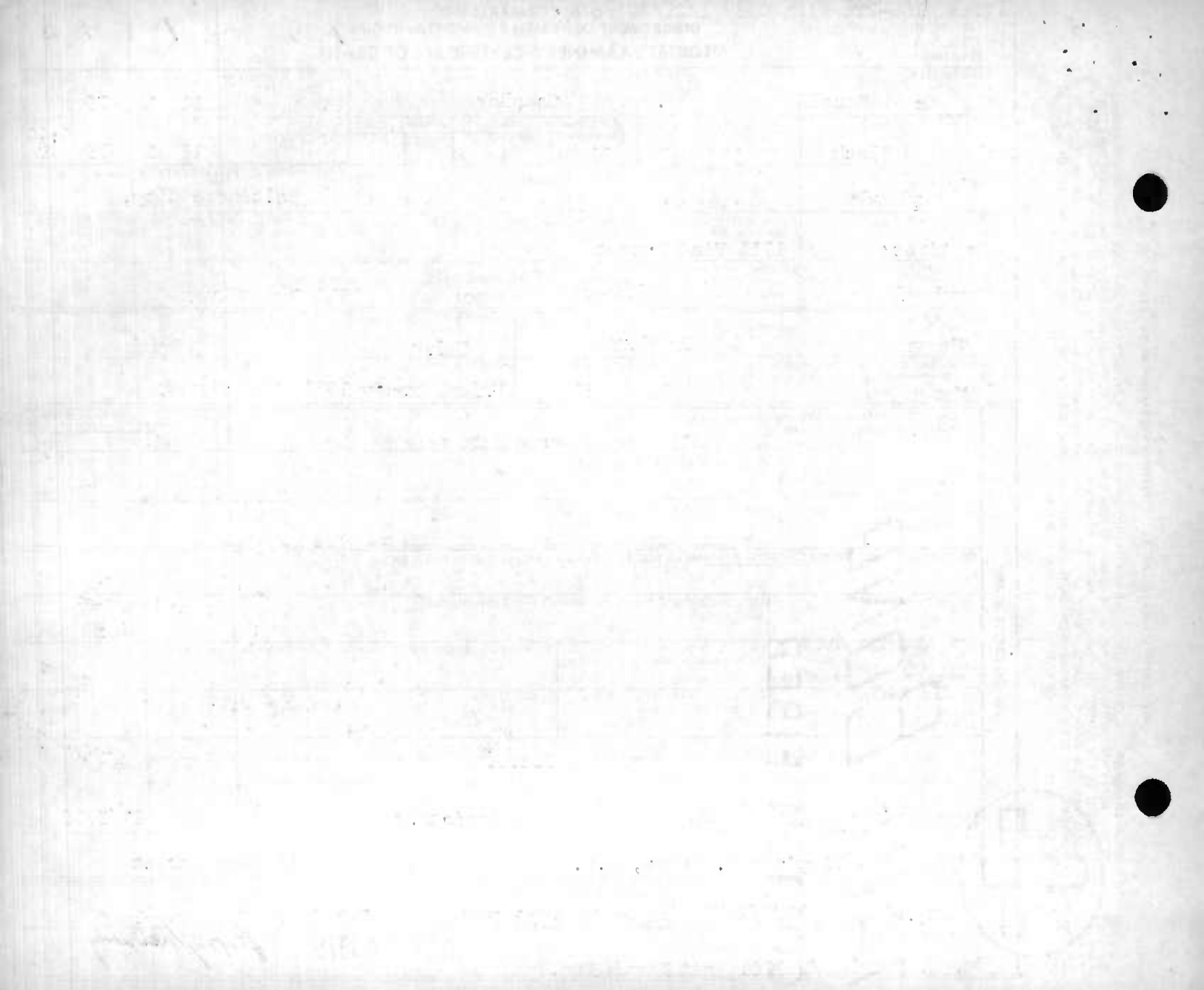
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH										2b. HOUR																			
1. DECEASED NAME (TYPE OR PRINT)										2. DATE KNOWN OF DEATH										2b. HOUR																			
Ronald J. Camphor										11 2 19 79										6:44 P M																			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR																									
Male		Black		8 17 47		32 YRS.						11 2 19 79		P M																									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																											
Maryland				U. S. A.								Baltimore City, MD.																											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																											
Baltimore				1711 Vine Street																																			
13a. STATE										13b. CITY OR TOWN										13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS																	
Maryland										Baltimore										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1711 Vine Street																	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																													
Thomas Camphor										Helen Smith																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT		ADDRESS																	
Yes										218-44-9623										Helen Grandy		1711 Vine Street																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I DEATH WAS CAUSED BY:																																							
3a49 IMMEDIATE CAUSE (a) Intravenous narcotism																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																																							
(b)																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																			
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																			
										P.M. 19																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																			
																				CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on death resulted from:										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																													
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																			
Virginia L. Dolan M.D.										Assistant										11/3/79																			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																													
Virginia L. Dolan, M.D.										111 Penn Street																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION									
Burial										11/8/1979										King Memorial Park										Baltimore Co., Maryland									
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
/Wm. C. March F/H										1101 East North Ave.										NOV 6 1979																			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 9 6

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAUDE M. CANE			2a. DATE OF DEATH MONTH DAY YEAR 11/ 3/ 79			2b. HOUR 9 <sup>20</sup> AM							
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 20 99		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KESWICK NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD.						13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1707 N. Wolfe St.	
14. FATHER'S NAME FIRST MIDDLE LAST John Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-12-7676		17. INFORMANT ADDRESS Mr. Herman Cane 1707 N. Wolfe St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C. ✓</u> 4392 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>March 29, 1979</u> , to <u>Nov 3, 1979</u> , that (I) <del>did</del> <u>did not</u> saw the deceased alive on <u>Nov 1, 1979</u> , and that in (my) <del>my</del> <u>my</u> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> <u>did not</u> view the body after death.													
22b. SIGNATURE <u>A. Allan Spier</u>				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/3/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ALLAN SPIER				22e. ADDRESS 700 W. 40th St. BALTO MD. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-7-79		23c. NAME OF CEMETERY OR CREMATORY MD. Nat'l. Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Md.					
24. FUNERAL DIRECTOR NAME Samuel T. Redd				ADDRESS 5209 York Rd. Balto. Md.				25a. DATE REC'D. BY REGISTRAR NOV 7 1979		25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

DHMH - 16 25M  
(VR A 15 (4)) 9/74

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 27197

REG. NO.

1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Capecci				2a. DATE OF DEATH MONTH DAY YEAR November 26, 1979				2b. HOUR A M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6 - 5-1919		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 256 S. Eaton Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		13d. STREET ADDRESS 256 S. Eaton Street	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Wagowich				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Kudela					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-01-5458		17. INFORMANT ADDRESS Mrs. M. Lotman					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). HEMORRHAGE 1991 DUE TO, OR AS A CONSEQUENCE OF (b). METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 19 79 to NOV. 19 79, that (I) (we) lost saw the deceased alive on NOV. 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.									
22b. SIGNATURE Aidan E. Walsh				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11-26-79	
22d. DECEASED'S NAME (TYPE OR PRINT) AIDAN E. WALSH				22e. ADDRESS 333 ST. PAUL BALTO MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/29/79		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Zannino Funeral Home, 263 S. Conkling St				25a. DATE REC'D. BY REGISTRAR NOV 26 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVA CARMODY					2a. DATE OF DEATH MONTH DAY YEAR 11-26-79					2b. HOUR 4:57 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 26, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CATON MANOR NSG CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland					13b. COUNTY Baltimore		13c. STREET ADDRESS 301 McMechin St.				
14. FATHER'S NAME FIRST MIDDLE LAST late William Deutsch					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Clara						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Fred Deutsch 3411 Dogwood Dr. Ellicott City					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>S/P Fracture Rt Hip. Dehydration</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this happens) attended the deceased from above, (b) (we) did (did not) view the body after death.										22c. DATE SIGNED 11/26/79	
22b. SIGNATURE S.D. AUSTIN A					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS 5400 Old Ct Rd RANDALLSTOWN						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov 28 '79		23c. NAME OF CEMETERY OR CREMATORY Woodlawn			23d. LOCATION Woodlawn, Balto, Maryland			
24. FUNERAL DIRECTOR NAME Harry H. Witzke 4112 Columbia Rd Ellicott City					25a. DATE REC'D BY REGISTRAR NOV 29 1979		25b. REGISTRAR'S SIGNATURE [Signature]				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 1 9 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>VINCENT</b>		MIDDLE <b>CARNAGGIO</b>		LAST <b>610</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 22, 1979</b>		2b. HOUR <b>9:20 AM</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-17-1897</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Colorado</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Producer-Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Ind.</b>		13b. COUNTY <b>Ind.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2858 W. North Avenue</b>	

14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Carnaggio</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Johnson</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-42-6466</b>	
17. INFORMANT <b>Phyllis R. Carnaggio</b>		ADDRESS <b>2858 W. North Ave</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest 20 myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>21/16</b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **11-22** 19 **79**, to **11-22** 19 **79**, that (I) (we) last saw the deceased alive on **11-22** 19 **79**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Joseph J. Kim</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/22/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH J. KIM</b>		22e. ADDRESS <b>Provident Hospital</b>			

23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		23b. DATE <b>11/26/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balti. Nat'l Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Ind.</b>	
24. FUNERAL DIRECTOR NAME <b>John J. Cowan</b>		ADDRESS <b>Box One, Hallin St.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Cowan</b>	

MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 0 0

REG. NO.

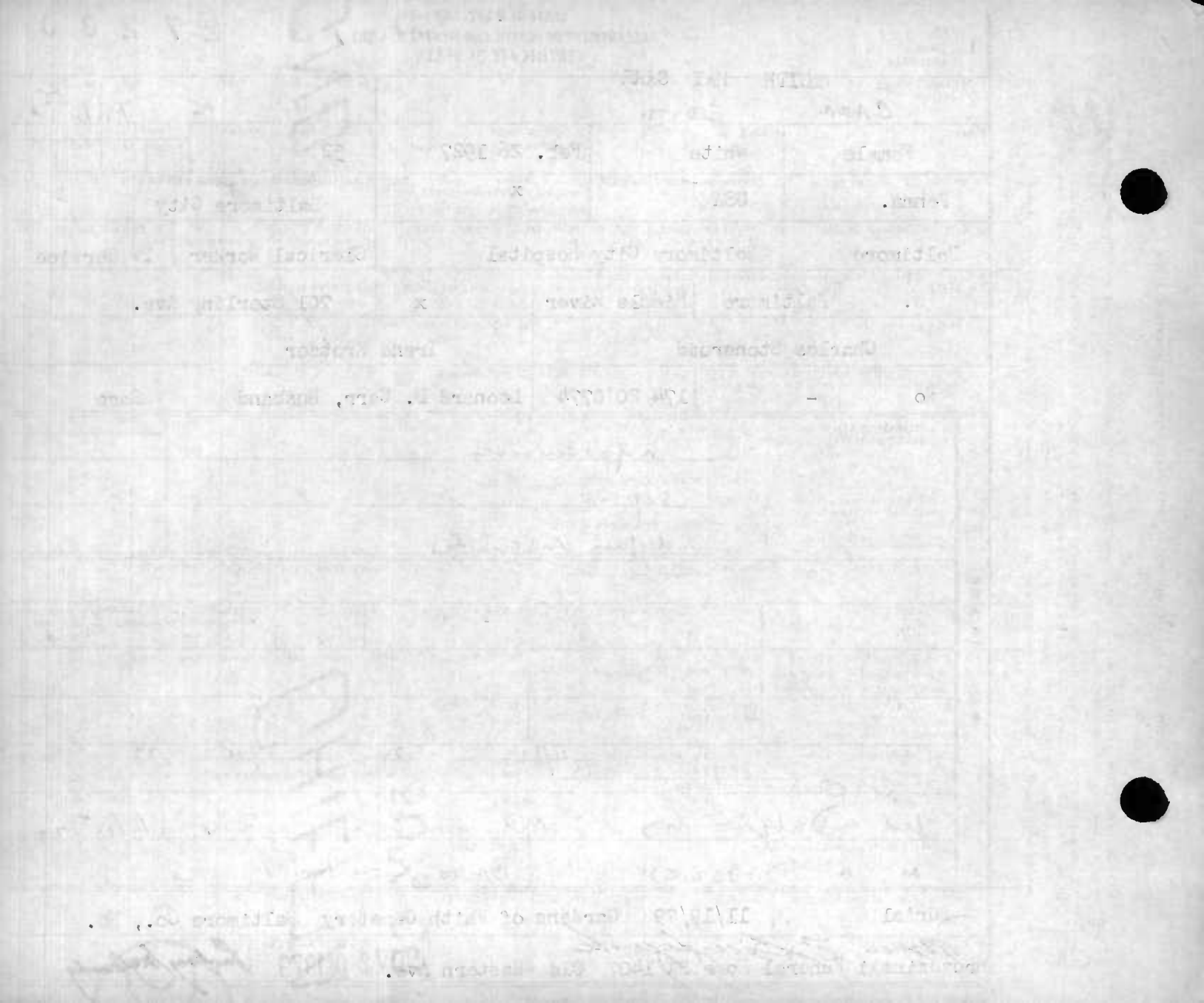
1. DECEASED NAME (TYPE OR PRINT) <b>EDITH MAY CARR</b> <b>CARR</b> <b>EDITH</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 15 79</b> <b>10<sup>55</sup> AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 26 1927</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS. MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerical Worker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>TV Service</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Middle River</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Stonerod</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Krotzer</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>174 20 0774</b>	17. INFORMANT ADDRESS <b>Leonard D. Carr, Husband</b> <b>Same</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>hypotension</b> <b>4476</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>diffuse vasculitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> , 19 <b>79</b> , to <b>11/15</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/15</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) did not view the body after death.			
22b. SIGNATURE <b>M. A. DABEZIES</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>11/16/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. A. DABEZIES</b>		22e. ADDRESS <b>BALTO CITY HOSPS</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/19/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 0 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE W. CARR</b>				2a. DATE OF DEATH MONTH <b>11</b> DAY <b>20</b> YEAR <b>79</b>				2b. HOUR <b>6:40P</b> M			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>5</b> YEAR <b>97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VETERANS ADMINISTRATION MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fireman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pa. Railroad</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Conowingo</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>BOX 264</b>			
14. FATHER'S NAME FIRST <b>SAMUEL</b> MIDDLE <b>W.</b> LAST <b>CARR</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b>A.</b> LAST <b>SHANK</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO <b>WW 1</b>		17. INFORMANT <b>VAMC Clinical Records</b>		17. ADDRESS <b>Baltimore, Md. 21218</b>					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>410 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Myocardial Infarction (Suggested by Autopsy)</b> (c) <b>CHF</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>R/O Lymphoma - histology pending</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 28, 1979</b> to <b>NOVEMBER 20, 1979</b> , that (I) (we) lost the deceased on <b>NOVEMBER 20, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Joseph A. Petrozza</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>11/21/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph A. Petrozza</b>				22e. ADDRESS <b>3900 Loch Raven Blvd. Balto., Md. 21218</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>26 Nov. 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Arlington Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Tarring Funeral Home, P.A., Aberdeen, Md. 21001</b>				ADDRESS <b></b>				25a. DATE RECEIVED BY REGISTRAR <b>NOV 28 1979</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

1. FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH										7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <b>Raymond C. Carr</b>										2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>3</b> YEAR <b>1979</b>										7b. HOUR <b>9:30 A M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>20</b> YEAR <b>1923</b>		6. AGE (IN YEARS AND BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH <b>11</b> DAY <b>3</b> YEAR <b>1979</b>		7d. HOUR <b>9:30 A M</b>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>									
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sheet metal work,</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>									
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>				13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>8026 Wynbrook Rd 21224</b>					
14. FATHER'S NAME FIRST <b>Alexander</b> MIDDLE <b>-</b> LAST <b>Carr</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>-</b> LAST <b>Ruckel</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>215-16-9418</b>				17. INFORMANT <b>Hattie Carr</b>				ADDRESS <b>8026 Wynbrook Rd.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4329</b> IMMEDIATE CAUSE (a) <b>Massive Intracranial Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) <b>Assistant</b>				MEDICAL EXAMINER				DATE SIGNED <b>11/4/79</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov, 7, 1979</b>				23c. NAME OF CEMETERY OR CREMATORY <b>OakLawn Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE									
24. FUNERAL DIRECTOR NAME <b>Lilly &amp; Zeiler Inc.</b> ADDRESS <b>1901 Eastern Ave. 21231</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 6 1979</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>													



1900, 20, 2000

1900, 20, 2000

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1900, 20, 2000

1900, 20, 2000



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 0 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Richard</i> FIRST MIDDLE LAST <i>Carrington</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-24-79</i>		2b. HOUR <i>10:20 AM</i>
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11 25 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <i>Maryland</i>	13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>2611 Reisterstown Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard Carrington</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ellen</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>577-07-8741</i>	17. INFORMANT ADDRESS <i>Agnes Carrington 2611 Reisterstown Road</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> <i>436-</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe Cachexia, dehydration, malnutrition.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebrovascular accident</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>11-24</i> 19 <i>79</i> to <i>11-24</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11-24</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Patterson</i> MD		DEGREE		22c. DATE SIGNED <i>11-24-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PATRICIA JENKINS MD</i>		22e. ADDRESS <i>2600 LIBERTY HEIGHTS AVE PROVIDENT HOSPITAL</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>11/28/79</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H 1101 East North Avenue</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 27 1979</i>		
			25b. REGISTRAR'S SIGNATURE <i>Patricia Jenkins</i>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 2 0 4				
1. FOR STATE REGISTRAR			REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
MARY			CARROLL						11-30-79			4:22 P.M.		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
F			B		8 18 87			92 YRS.			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA			USA						BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE CITY			JOHNS HOPKINS						UNEMPLOYED			B		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
MD			BALTIMORE CITY		BALTIMORE CITY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2017 Westwood Ave 2101				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
WILLIAM			SUSAN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
NO			214-54-4114		OLD CHART									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease										25 years				
4292 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
Diabetes mellitus; renal insufficiency														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
NA			NA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			NA			NA								
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION								
NA			NA			NA								
22a. I certify that (I) (this hospital) attended the deceased from JUNE 19 73, to NOVEMBER 19 79, that (I) (we) last saw the deceased alive on 11/30 19 79, and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED					
STUART B. BAKER			MD						11/30/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
STUART B. BAKER			JOHNS HOPKINS HOSPITAL											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			COUNTY STATE			
Burial			12/7/79		Arlington			Baltimore			MD			
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
William McLean			DEC 3 1979			R. H. H. H.								









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 0 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William F. Carter</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 23, 1979</b>		2b. HOUR <b>4:25</b> M	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 7 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Carter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Burns</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>219-07-5815</b>		17. INFORMANT ADDRESS <b>Rose Williams 2516 East Federal Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>END STAGE LUNG DISEASE, POSSIBLE SEPSIS, POSSIBLE P.E.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LUNG DISEASE, PROBABLY RELATED TO SMOKING</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEPSIS, POSSIBLY 2° TO URINARY TRACT INFECTION, PNEUMONITIS, DECUBITI</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>PAST HISTORY OF MI, PLUS MALNUTRITION</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/16/79</b> , 19____, to <b>11/23/79</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/23/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Cannistra</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/23/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CANNISTRA</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/28/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 East North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

WICHA





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 0 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN S. CASSELL SR.				2a. DATE OF DEATH MONTH DAY YEAR 11 6 79		2b. HOUR 800 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08 10 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY STATE OF	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN WOODLAWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH CASSELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA BRITCHER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-10-3858		17. INFORMANT ADDRESS JOHN S. CASSELL, JR., 708 MILFORD MILL ROAD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>carcinoma lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-3</u> , 19 <u>77</u> , to <u>11-6</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11-6</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>C. Shah</u>				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/6/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. G. SHAH				22e. ADDRESS 900 CATON AVE. BALTIMORE, MD. 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-09-79		23c. NAME OF CEMETERY OR CREMATORY WARDS CHAPEL		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTO. MD.	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.				25. DATE RECEIVED BY REGISTRAR NOV 9 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



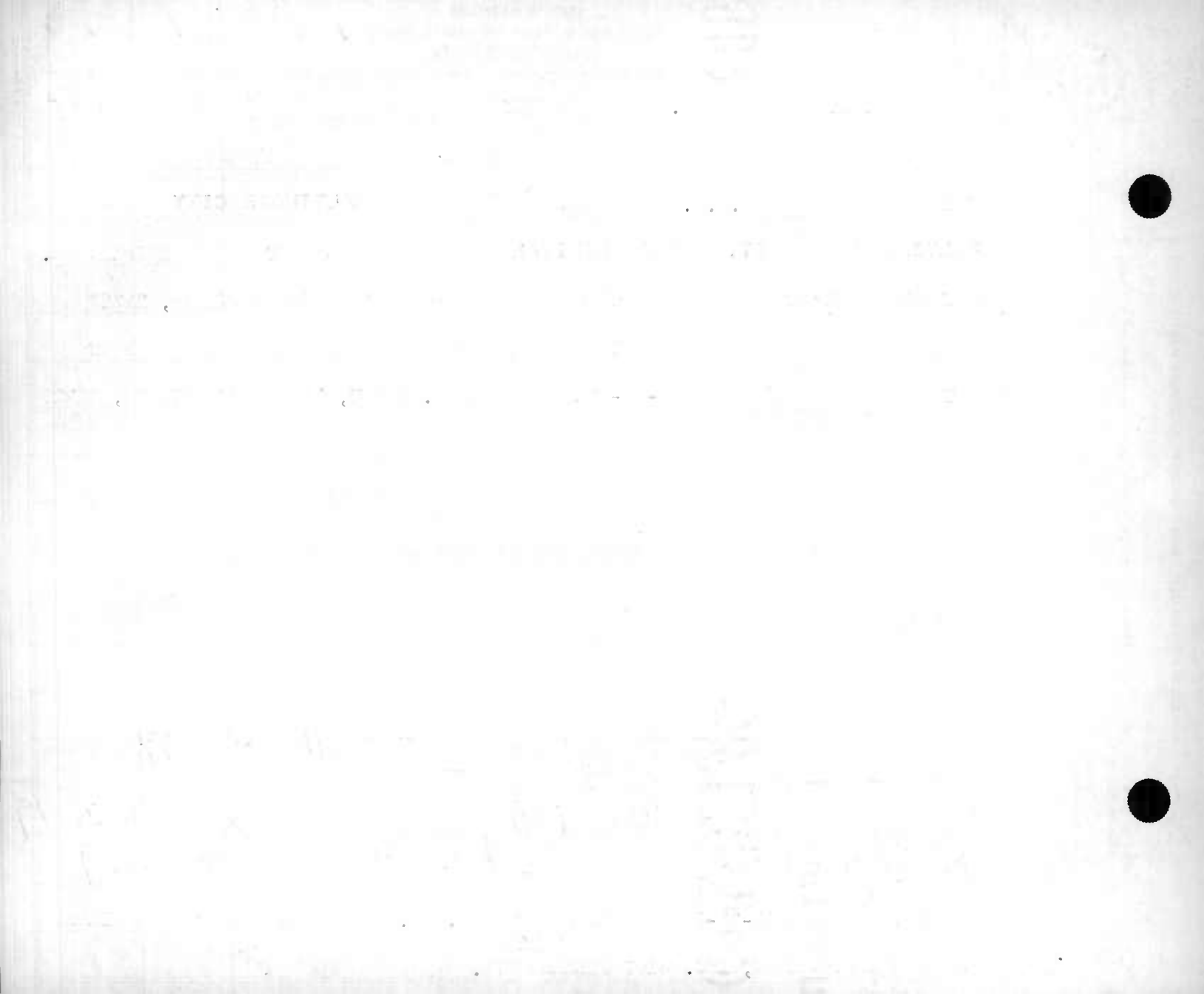
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN L. CAVEY					2a. DATE OF DEATH MONTH DAY YEAR 11 20 79		2b. HOUR 1.05A M		
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06 13 18		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY KOPPERS CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN LANSDOWNE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 244 SECOND AVENUE, 21227	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD CAVEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE BEST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 217-09-8347		17. INFORMANT ADDRESS LILLIAN C. CAVEY, 244 SECOND AVENUE, 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>circulatory failure</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>metastatic adeno-Ca of the colon</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION July 79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca colon				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-13</u> 19 <u>79</u> to <u>11-20</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-19</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE N. SCHMUELLER				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 11.20.79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. SCHMUELLER				22e. ADDRESS St. Agnes Hospital Balto 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-23-79		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR NOV 21 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

BP \_\_\_\_\_

DHMM-16 20M  
(VRA 15, 4) 7/78



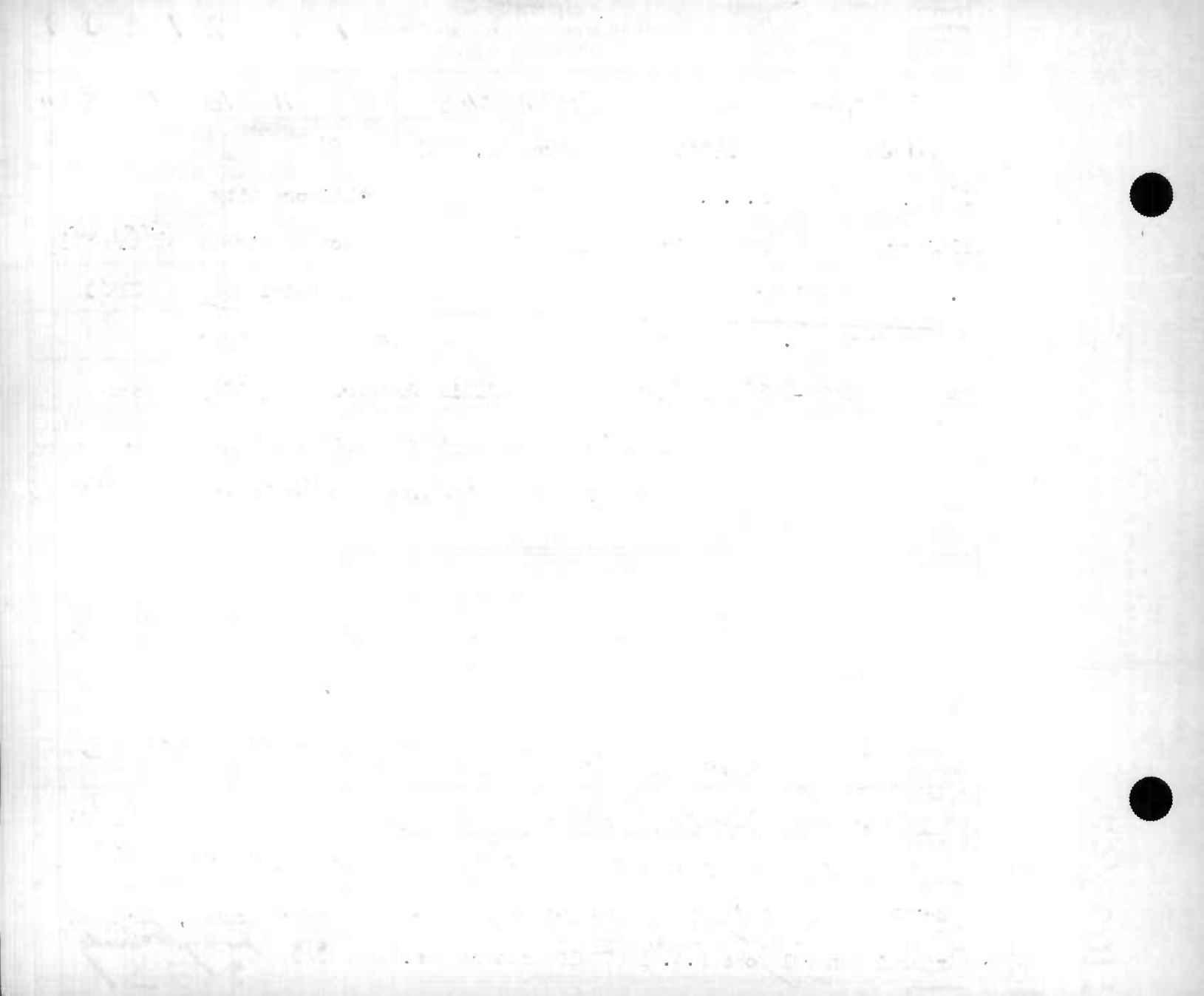
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 2 0 9			
1. FOR STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH G. CHAMBERS</b>					2a. DATE OF DEATH MONTH <b>11</b> DAY <b>16</b> YEAR <b>77</b>				2b. HOUR <b>8pm</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>March</b> DAY <b>21</b> YEAR <b>1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		# UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		# UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clock Repairman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Watch Shop</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Essex</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>222 Pantat Road</b>		13f. ZIP CODE <b>21221</b>				
14. FATHER'S NAME FIRST <b>Goodhart</b> MIDDLE <b>J.</b> LAST <b>Chambers</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Josephine</b> MIDDLE <b>Yeager</b> LAST <b></b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO <b>1934-1936</b>		17. INFORMANT <b>Lillie Chambers</b>		ADDRESS <b>(Wife)</b>		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>45 min</b> <b>7 hours</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERFORMED ANGIOPLASTY</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <b>11-6</b> , 19 <b>77</b> , to <b>11/16</b> , 19 <b>77</b> , that (b) (we) lost saw the deceased alive on <b>11/16</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Charles Hoescio M.D.</b>					DEGREE <b>M.D.</b>					22c. DATE SIGNED <b>11/16/77</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES HOESCIO M.D.</b>					22e. ADDRESS <b>9712 BELMONT ROAD // DISTRICT 21236</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/20/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Howard County, Maryland</b> COUNTY STATE					
24. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home P.A.</b>					ADDRESS <b>1407 Old Eastern Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 3 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 7 9 2 7 2 1 0									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
VERNON		E.		CHAPPELL				NOVEMBER 10, 1979		4:26 P	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN	
Male		Negro		2 26 1912		67 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U. S. A.				BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		THE JOHNS HOPKINS HOSPITAL									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland				Baltimore				633 North Aisquith Street			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Charles Chappell						Annie					
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No				218-07-1701		Anna Chappell 1130 North Calhoun Street					
18 CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>										Immediate	
1991 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adenocarcinoma</u>										2 1/2 y	
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> 19 <u>79</u> to <u>11/10</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/10</u> 19 <u>79</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Walter L. Bender MD</u>						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>11/10/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WALTER L. BENDER MD</u>						22e. ADDRESS <u>601 N. Broadway Balto, Md 21205</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		11/16/1979		Mount Auburn Cemetery		Baltimore, Maryland					
24 FUNERAL DIRECTOR NAME <u>Wm. C. March F/H</u> ADDRESS <u>1101 East North Avenue</u>						25a. DATE REC'D. BY REGISTRAR <u>NOV 13 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

NOVEMBER 10, 1935

CHICAGO

WILLIAM

THE JOHN H. ...

10/11/35





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 2 7 2 1 1
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) WALTER CHESSES					2a. DATE OF DEATH MONTH DAY YEAR 11-24-79					2b. HOUR 12:45 PM
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10-09-1899		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW GER. CNTR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHARMACIST		12b. KIND OF BUSINESS OR INDUSTRY DRUGS		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE MD		13b. COUNTY XXXXXXX		13c. CITY OR TOWN BALT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6005 HIGHGATE DR. #21215		
14. FATHER'S NAME FIRST MIDDLE LAST NATHAN CHESSES					15. MOTHER'S MAIDEN NAME FIRST MIDDLE FANNIE UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 294-10-7088		17. INFORMANT HEBREW BURIAL & SOC. SERVICE 1330 REISTERSTOWN RD. BALTO., MD 21208						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Cancer Colon, Low pressure Hydrocephalus, Chronic Brain Syndrome</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from <u>10/6/77</u> to <u>11/24/79</u> , that (I) (we) last saw the deceased alive on <u>12/20/79</u> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Khin M. Tun</u>					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/24/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KHIN M. TUN					22e. ADDRESS 2110 Pot Spring Road Balto Md 21093					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE NOV. 27, 1979		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215					25a. DATE REC'D. BY REGISTRAR NOV 28 1979		25b. REGISTRAR'S SIGNATURE <u>Frederick Helms</u>			

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## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Augustus N. Chin</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 25 79</b>			2b. HOUR <b>M</b>				
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 12 27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1627 Patterson Park Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Chin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie Miller</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-20-3424</b>		17. INFORMANT ADDRESS <b>Shirley M. Chin 1627 Patterson Pk. Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypertensive Cardiovascular Disease 5 Yrs.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 Yrs.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5</b> - <b>11</b> 19 <b>74</b> to <b>11-25</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-24-</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Eugene H. Owens M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-29-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eugene H. Owens</b>						22e. ADDRESS <b>1735 E. Federal St</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/1/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Ricky McBrady</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR	
MAGGIE		CHRISTOPHER		11		22		79		1:50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		BLACK		06 22 90		89 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
N/A		U.S.A.				BALTO CITY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTO.		UNIV OF MD. HOSPITAL		Homemaker							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD.				21217		YES <input type="checkbox"/> NO <input type="checkbox"/>		827 ARLINGTON AVE.			
14. FATHER'S NAME (TYPE OR PRINT)		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)									
George A		Della N/A									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
N/A		219-36-8230		Mr. Edward Christopher		1100 Bolton St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4039		cardiac arrest		severe end stage congestive heart failure		2 wks.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF							
				(c) hypertension							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		① possible aspiration pneumonia		② Cerebrovasc. accident							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from		11/6/79		19 79		to 11/22		19 79		that (I) (we) lost saw the deceased alive on 11/22 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
Joan M. Bathon		MD				11/22/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Joan M. Bathon MD		UNIV OF MD. HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
BURIAL		11-26-79		Arbutus Memorial Park		BALTO		Cecil		MD	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
JOSEPH		RUSS 2222 W. NORTH AVE.		DEC 3 1979		Ruthy K. Kline					

MEDICAL CERTIFICATION

9  
9

1601 BP



RECEIVED

THE SECRETARY OF THE  
TREASURY

WASHINGTON, D. C.

DEPT. OF THE TREASURY

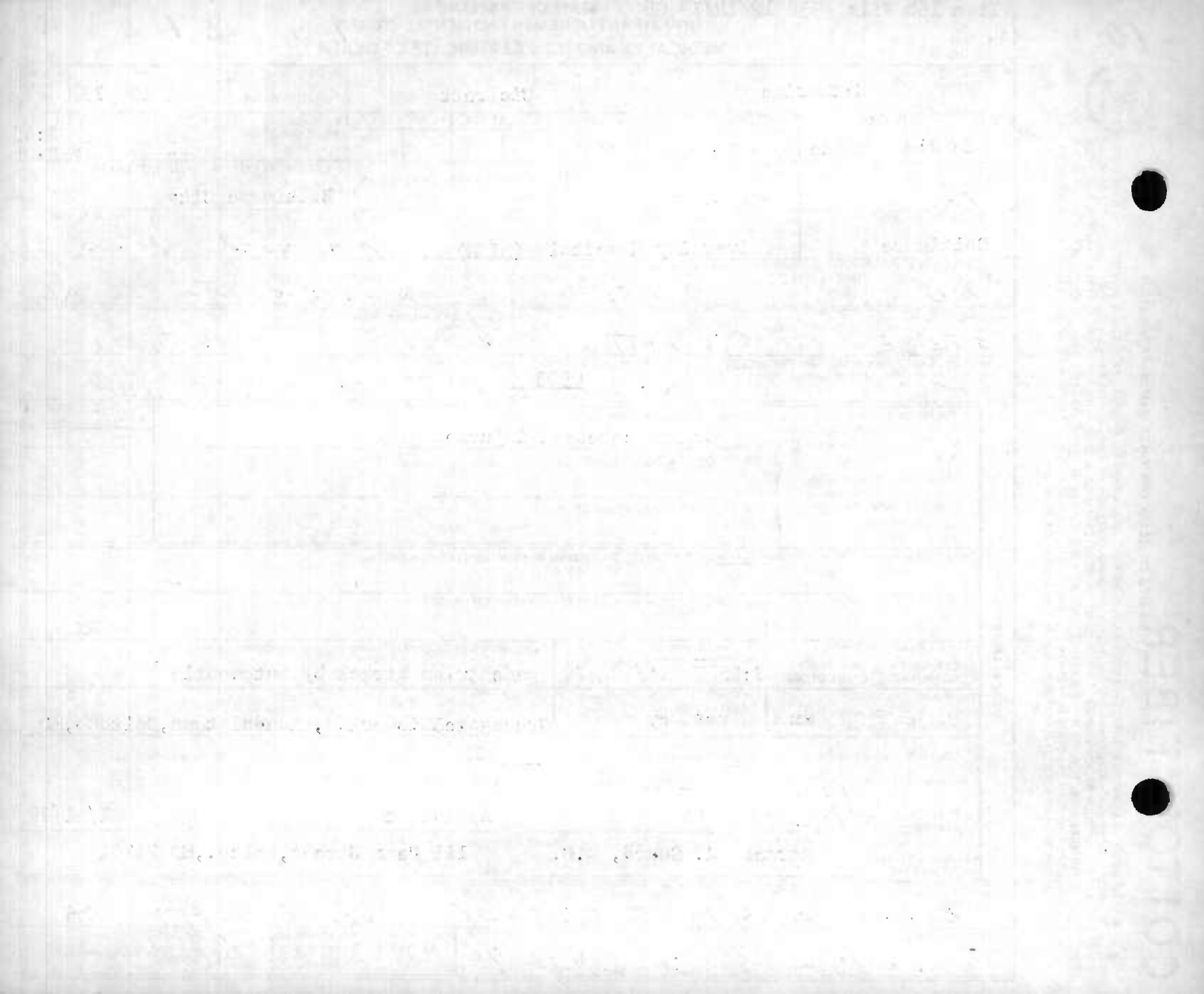
OFFICE OF THE ASSISTANT SECRETARY

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 16b Film #538 12/14/79 GB STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 9 27214	
1. DECEASED NAME (TYPE OR PRINT) <b>Catherine Ciciretto</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 10 19 79</b>		2b. HOUR <b>8:45 P.M.</b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-23-31</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital (MIEM)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MANAGER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL SALES</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1616 CANTWELL RD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>STEVE Ciciretto</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCIA INTINI</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>0503 169-24-7515</b>		17. INFORMANT ADDRESS <b>PAT BRADY-429 FRANKLIN</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cranio cerebral injuries</b> 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>7:25</b> MONTH <b>11</b> DAY <b>10</b> YEAR <b>19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>pedestrian struck by automobile</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>roadway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Greengage &amp; Winder Rds, Randalstown, Balto Co, MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>H R Guard</b>				TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>11/11/79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. GERTUDE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>VANDERGRIFT PA.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Jerome Della Rosa 322 E High St.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					







WLR3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 25M  
(VRA 15, 4) 1/79

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 2 7 2 1 5 REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Felicia Clark</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 30, 1979</b>		2b. HOUR <b>12:20a</b>	
3 SEX <b>F</b>	4 RACE <b>NEGRO</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>1 27 95</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>BALTO.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1401 N. Central AP</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>HOWARD Smith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS <b>EDWARD CLARK 1401 N. Central AP</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 10, 1979</b> to <b>Nov 30, 1979</b> , that (I) (we) lost saw the deceased alive on <b>Nov 30, 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.					
22b. SIGNATURE <b>Julia Wren</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/30/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIA WREN</b>		22e. ADDRESS <b>WILMER 3 MED., JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>		24 FUNERAL DIRECTOR NAME ADDRESS <b>LOCKS FUNERAL HOME 1304 N. Central AP</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



OFFICE OF THE  
DIRECTOR

NOV 20 1978

NOV 20 1978

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hilda C. Clark										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11 11 1979										7b. HOUR M A			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 25 18		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 11 13 1979										7d. HOUR 8:40 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.											
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2121 Windsor Garden Lane, Apt. 519										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE Maryland				13b. COUNTY				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2121 Windsor Garden Lane							
14. FATHER'S NAME FIRST MIDDLE LAST Clarence M. Diggs										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Cooper													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 216-24-3453				17. INFORMANT ADDRESS Geneva Motley 4630 Homer Avenue															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>Arteriosclerotic Cardiovascular Disease</u> IMMEDIATE CAUSE (a) <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 11/13/79											
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/17/1979				23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland											
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 East North Avenue										25a. DATE REC'D. BY REGISTRAR NOV 16 1979				25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>									



*[Faint, mostly illegible text across the page, possibly bleed-through from the reverse side.]*

*[Handwritten signature or initials.]*  
MAY 10 1969

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 1 7

1- FOR  
STATE  
REGISTRAR

MARCUS

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARCUS G. CLARKE			2a. DATE OF DEATH MONTH DAY YEAR 11-12-79			2b. HOUR 11:55 PM			
3. SEX MALE		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 4 6 12		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EDGEWOOD NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ICE CREAM SALES		12b. KIND OF BUSINESS OR INDUSTRY GOOD HUNOR	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD BALTO PARKVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3216 Taylor Ave				
14. FATHER'S NAME FIRST MIDDLE LAST CARROLL C. CLARKE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MYRTLE RICK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A 2		17. INFORMANT FAMILY MEMBERS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. Cerebral Infarcts. 4349 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis - DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED 11/13/79		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/12/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anthony F. Carozza			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY F. CAROZZA			22e. ADDRESS 6000 BELLOUXA AVE BALTO MD 21212						
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL			23b. DATE 11-15-79		23c. NAME OF CEMETERY OR CREMATORY GARDENS of FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO CO MD		
24. FUNERAL DIRECTOR NAME EVANS			ADDRESS 8800 NORTON RD			25a. DATE REC'D. BY REGISTRAR NOV 19 1979		25b. REGISTRAR'S SIGNATURE Anthony F. Carozza	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text, possibly a date or reference number, appearing as "A2700" or similar.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 2 1 8			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
MARY		CLAYTON						NOVEMBER 9 1979					12m M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Negro		11 8 1899		80 YRS.		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Ala.		U. S. A.				BALTIMORE CITY						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		JOHNS HOPKINS HOSPITAL											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1763 East North Avenue					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Sie		Lang		Cherry		Dillard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS							
		218-09-8910		Rosa Gladden		1763 East North Avenue							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Cardio pulm. arrest</u>													
DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET									
				CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>79</u> , to <u>11/9</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
Andrew Laster MD.								11/9/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
Andrew Laster				J. H. H.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		11/14/79		Mount Calvary Cem.		Baltimore, Maryland							
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
NAME		ADDRESS											
Wm. C. March F/H		1101 East North Avenue		NOV 14 1979									

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/01 BY 60322 UCBAW

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 2 1 9	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR	
Bernard Roy Coates			11-25-79		545		A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
MALE		BLACK		10-29-24		55 YRS		MONTHS		DAYS	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		9c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9d. BALTIMORE CITY OR COUNTY OF DEATH					
Md		USA				Balto					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Balto			Barn Secours								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS		
Md			Balto			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2308 W Fayette St		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
AMOS			Rosie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
YES			ARMY			217-16-3228			Front of Chart 2308 W. Fayette St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a):											
4292 Cardiorespiratory arrest											
DUE TO, OR AS A CONSEQUENCE OF (b):											
Arteriosclerotic Cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF (c):											
Metastatic carcinoma of throat											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 24, 1979, to Nov. 25, 1979, that (I) (we) last saw the deceased alive on 11-25-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
Frank A. Hamilton			MD			11-2-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
FRANK A. HAMILTON			Barn Secours Hospital								
			2025 W. FAYETTE ST., BALT. MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			11/30/79			King Memorial Park			Baltimore Co., Maryland		
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Wm. C. March F/H 1101 East North Avenue						NOV 28 1979			[Signature]		

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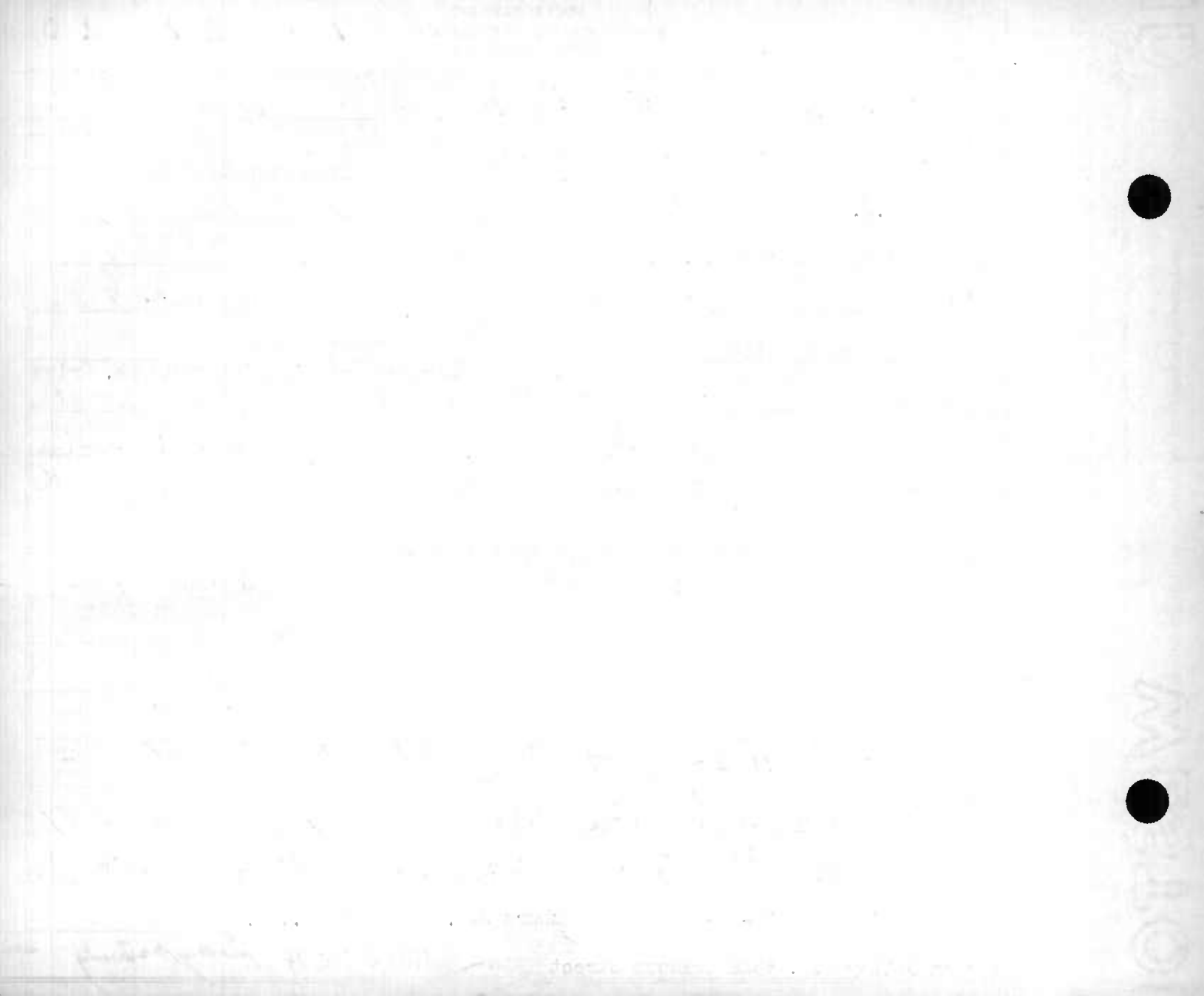
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 2 2 0	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>NORMA Edith Cole</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11 25 79</b>		2b. HOUR <b>6:30 A.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 15 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KEY CIRCLE HOSPICE</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13b. STREET ADDRESS <b>1214 Eutaw PLACE</b>			
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Angus White</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vernie Gross</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>216-03-4419</b>		17. INFORMANT <b>Barbara Griffin</b> ADDRESS <b>2344 Druid Pk. Drive</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> 3500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> (c) <b>several months</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>ASCVD</b> <b>several years</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>11-25</b> 19 <b>77</b> , to <b>11-25</b> 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>11-25</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>E. Ellsworth Cook MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>11-27-79</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Ellsworth Cook</b>						22e. ADDRESS <b>2431 Maryland Ave. Balto. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-29-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cem.</b>		23d. LOCATION CITY OR TOWN <b>Balto., Md.</b> COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Vernon Bailey F.H.</b> ADDRESS <b>1348 Calhoun Street</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 2 2 1	
FOR 1- STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST MARIE ANGELA COLLINS			2a. DATE OF DEATH MONTH DAY YEAR 11 12 79			2b. HOUR 10:50 A.M.		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR October 3, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Will			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Theresa Hand			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					
16b. SOCIAL SECURITY NO. 220-03-3336			17 INFORMANT WILLERSVILLE, MARYLAND 21108 Patricia A. Scott, 280 Michelle Circle								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>POOR MYOCARDIAL INFARCTION</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE ISCHEMIC CARDIO-VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>11/11/79</u> to <u>11/12/79</u> , that (I) (we) lost saw the deceased alive on <u>10/17/79</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>John H. Shaw, M.D.</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/12/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Shaw, M.D.			22e. ADDRESS 5800 Edmondson Avenue Catonsville, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/15/79		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24 FUNERAL DIRECTOR NAME Witzke Funeral Home of Catonsville			24b. ADDRESS 1630 Edmondson Avenue Catonsville, Maryland			25a. DATE REC'D. BY REGISTRAR NOV 16 1979		25b. SIGNATURE <u>John H. Shaw, M.D.</u>			

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FOR  
STATE  
REGISTRAR

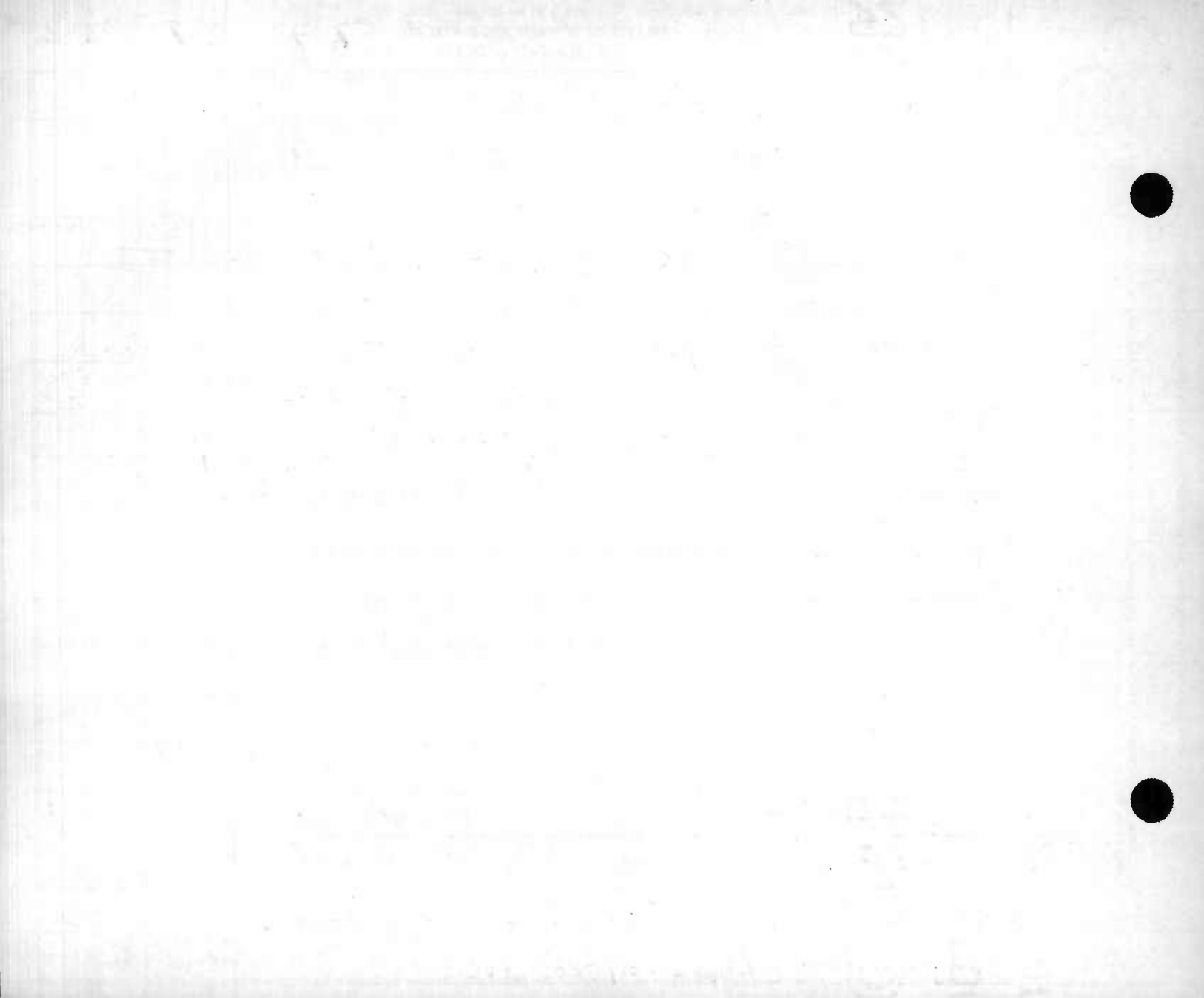
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY LILLIAN COLLINS			2a. DATE OF DEATH MONTH DAY YEAR 11 27 79		2b. HOUR 8 A. M.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 11 9 88	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS 19
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY —
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD.	13b. COUNTY BALTO	13c. CITY OR TOWN SPYKESVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 7312 1ST AVE	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY A. VOE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET O'DONNELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-07-1419D		17. INFORMANT ADDRESS AGNES METUSAVEG 139 S. SYMMINGTON AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST. 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease. DUE TO, OR AS A CONSEQUENCE OF (c) —					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-19-19-77, to 11-27-19-79, that (I) (we) last saw the deceased alive on 11-20-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b. SIGNATURE (a)		DEGREE MD		22c. DATE SIGNED 11-27-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DARSHAN S. SALUJA		22e. ADDRESS 1600 MT Royal Lane, Balti 21217			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 11-30-79	23c. NAME OF CEMETERY OR CREMATORY NEW CATH. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME Family Funeral Home		ADDRESS 6601 FRED. AVE.		25a. DATE REC'D. BY REGISTRAR DEC 3 1979	25b. REGISTRAR'S SIGNATURE Rickey McCreedy

BP \_\_\_\_\_





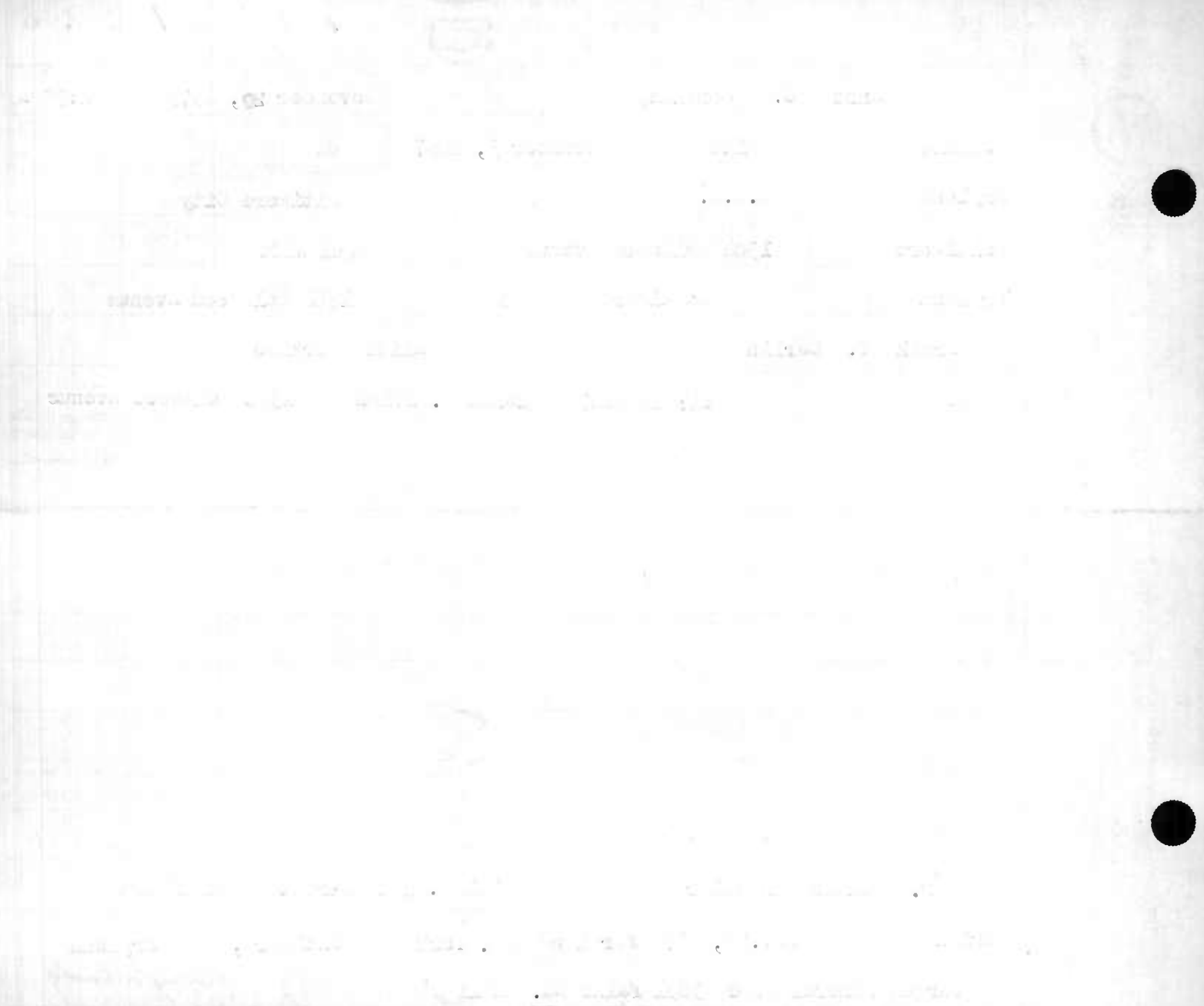


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 2 2 3	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Anna C. Conolley</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 20, 1979</b>				2b. HOUR <b>1:30 A.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 3, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1304 Dellwood Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1304 Dellwood Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank T. Carlin</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Perkins</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217 16 4217</b>		17. INFORMANT <b>Elaine R. Ivins</b>		ADDRESS <b>1306 Dellwood Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interarteriole Cardiac vascular Disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Sheldon Goldgeier</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/20/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Sheldon Goldgeier</b>				22e. ADDRESS <b>711 W. 40th Street Baltimore</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 23, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Burgee Funeral Home</b>				ADDRESS <b>3631 Falls Rd. 21211</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 7 2 2 4			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MERRIELD H. CONROY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 27 79</b>		2b. HOUR <b>4:00A</b>	
3. SEX <b>Fem.</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 28 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>66 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Balto.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Kaine</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Mask</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				17. INFORMANT ADDRESS <b>215-09-4837D Mr. Donald L. Conroy 5508 Carter Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 436- DUE TO, OR AS A CONSEQUENCE OF: b) <b>Hypertension</b> c) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Diabetes Mellitus ; Aspiration Pneumonia</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <b>11/25 1979</b> to <b>11/27 1979</b> , that (I) (we) last saw the deceased alive on <b>11/27 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Fredric Stewart Sirkis MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/27/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FREDRIC STEWART SIRKIS</b>				22e. ADDRESS <b>MERCY Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-30-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc.</b>				ADDRESS <b>6415 Belair Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>	
						25b. REGISTRAR'S SIGNATURE <i>Frederick A. Conroy</i>	

TO THE SECRETARY OF THE INTERIOR  
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to fading and bleed-through from the reverse side of the page. It appears to be a memorandum or report.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 2 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Arnedia E Contee</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 14, 1979</b>		2b. HOUR <b>12:55pm</b>			
3 SEX <b>Female</b>	4 RACE <b>Black</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>7/29/1916</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>63</b>	7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8. IF UNDER 24 HRS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Md.</b>	13b. COUNTY	13c. CITY OR TOWN <b>Balto.</b>	13e. STREET ADDRESS <b>2904 Winchester St.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lawrence Cassell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Lewis</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Lawrence Contee 5512 Peerless</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Atherosclerotic Cardiovascular Disease 8 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>August 1975</b> , to <b>November 14, 1979</b> , that (1) (we) lost saw the deceased alive on <b>11/13</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Walter Bender</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/14/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER BENDER MD</b>		22e. ADDRESS <b>601 N Broadway Balto Md 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/17/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Jas. A. Morton 1701 Laurens St.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 2 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Viola m Cook</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 24 79</i>		2b. HOUR <i>12:55 PM</i>						
3. SEX <i>F</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6 14 08</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i>		IF UNDER 1 YEAR MONTHS DAYS <i>11 24</i>		IF UNDER 24 HRS HOURS MIN <i>12 55</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>America</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Providence Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>none</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Maryland</i>		13b. COUNTY <i>America</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3401 Mondawmin</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>David W. GROSS</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha A. Gross</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-24-8939</i>		17. INFORMANT ADDRESS <i>Vivian W. TATONE 3401 Mondawmin Ave.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypoxia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>LLL pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>?</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>unknown</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Providence Hosp.</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Liberty Heights Ave. Balto. Md.</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>11/24</i> , 19 <i>79</i> , to <i>11/29</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>11/24</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Lenox S. Dingle, MD</i>						DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/24/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lenox S. Dingle, MD</i>						22e. ADDRESS <i>Providence Hospital</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>11/29/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. AUBURN</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO. Maryland Md.</i>					
24. FUNERAL DIRECTOR NAME <i>James D. Pitt</i>						ADDRESS <i>4600 Liberty</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 29 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert M. ...</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove co-bonopopers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 7 2 2 7			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				REG. NO.			
SUSAN B. COOKE				NOV. 2, 1979				104 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		7c. MIN.	
F		W		8/14/93		86 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PA.		USA				BALTO. CITY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTO		LONG GREEN N.H.				HSEW					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
MD.				BALTO		MIDDLE RIVER				1002 FUSELAGE AVE	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
ARTHUR BARTH				UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				166 09 9142		ALBERT BARTH		ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 4292										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b).											
DUE TO, OR AS A CONSEQUENCE OF (c).											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)					
22a. I certify that (I) (this hospital) attended the deceased from 11/5/79 to 11/5/79 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (not) view the body after death.				22b. SIGNATURE		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>					
WM. HELFRICH				5006 ROLAND AVE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL				11/5/79		GREENMOUNT		PHILA. PA.			
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J.G. CONNELLY				300 MAE		NOV 08 1979		[Signature]			

BP



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2024-2025

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VR 15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27228	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>John T. Coombe</b>						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>11 11 19 79</b>		2b. HOUR <b>12:15 a.m.</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9/13/62</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>17</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>11 11 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital (MIEM)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Pennsylvania</b>				13b. COUNTY <b>Newtown Square</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>305 Crum Creek Lane</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John T. Coombe</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara Dougherty</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Marvil Funeral Home, Darby, Pa.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries</b> 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>10:15PM 11/10/79</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10:15PM 11/10/79</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver of auto in collision with truck</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>roadway</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt 144 West of Folley Quarter Rd, Howard Co. MD</b>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Hormez R. Guard</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>11/11/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>11/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sts. Peter &amp; Paul</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marple Township, Pa.</b>			
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
ADDRESS <b>4905 York Road Balto., Md. 21212</b>											

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STATE OF CALIFORNIA  
COUNTY OF SAN DIEGO  
IN SENATE  
JANUARY 1, 1900  
REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
FOR THE YEAR  
1899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Each copy be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 2 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2r. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	A
AMELIA				COOPER	NOVEMBER 4, 1979					7:40	M
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		7 UNDER 24 HRS		
Female	Black		MONTH DAY YEAR 18 02		77 YRS.		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD						
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Balto.	THE JOHNS HOPKINS HOSPITAL		Housewife								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13r. STREET ADDRESS						
MD.	Balto	BALTO			155 Lionhead Ct.						
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
James W Pulley				Harriet Ann Smith							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
NO				None		Hortense D. Cooper 155 Lionhead Ct.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> <u>2773</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>amyloidosis &amp; monoclonal gammopathy</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>one month</u> <u>unknown</u>										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)	
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>10/6</u> 19 <u>79</u> to <u>11/4</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/4</u> 19 <u>79</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.											
22b SIGNATURE				DEGREE				22c DATE SIGNED			
James W. Young MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				11/4/79			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
JAMES W. YOUNG MD				Johns Hopkins Hosp Balto, MD 21205							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		11-8-79		Sharp St. Church Cemetery		Balto Balto Md.					
24 FUNERAL DIRECTOR NAME ADDRESS				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
William C Brown 1206 08 W. North St.				NOV 7 1979		R. J. Baker					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

COOPER, MICHAEL J  
7 70 28 45 2 3 0

1 DECEASED NAME (TYPE OR PRINT) <b>MICHAEL COOPER JR</b>			2a DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 7 1979</b>			2b HOUR <b>1:45AM</b>					
3 SEX <b>MALE</b>		4 RACE <b>COL</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>OCT 28, 1975</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>4</b>		6b IF UNDER 1 YEAR HOURS MIN <b>4</b>			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10 CITY OR TOWN OF DEATH <b>BALTIMORE MD</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CHILD</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b>			13b COUNTY <b>BALTIMORE</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>6135 ST. PETERS ROAD</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>MICHAEL COOPER SR</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VANESSA BLACKWELL</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b SOCIAL SECURITY NO	
17 INFORMANT ADDRESS <b>Mrs VANESSA BLACKWELL 6135 ST. PETERS ROAD</b>											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular failure</b> <b>0362</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>meningococcal sepsis</b> (c) <b>meningococcal sepsis</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>24 hours</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET <b>6135 ST. PETERS ROAD</b>		21g CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>11-6</b> 19 <b>79</b> , to <b>11-7</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11-7</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>David Siegel</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>11-7-79</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID SIEGEL</b>			22e ADDRESS <b>Johns Hopkins Hospital</b>								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>B</b>			23b DATE <b>11/10/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Bethesda</b>		23d LOCATION CITY OR TOWN <b>Bethesda</b>		23e COUNTY <b>md</b>		
24 FUNERAL DIRECTOR NAME <b>Joseph C. Rums</b>			ADDRESS <b>2222 North Ave</b>			25a DATE REC'D. BY REGISTRAR <b>NOV 15 1979</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 2 7 2 3 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM B. CORBETT</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 25, 1979</b>			2b. HOUR <b>11:38 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 30, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
13a. STATE <b>Florida</b>		13b. COUNTY <b>Holiday Lake Estates</b>		13c. CITY OR TOWN <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>		13d. STREET ADDRESS <b>209 Fairmount Drive West</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Matthew Corbett</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Esther Flynn</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>028 10 7956</b>		17. INFORMANT ADDRESS <b>Boston, Mass.</b> <b>Waterman &amp; McDonald Funeral Home</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BACTERIAL PERITONITIS</b> <b>586 -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UREMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>TEN DAYS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HEPATIC CIRRHOSIS - POST TRANSFUSIONAL</b>									
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>25 NOV 79</b>		CITY OR TOWN <b>25/NOV 79</b>		COUNTY <b>11/25/79</b>	
22a. I certify that (I) (the hospital) attended the deceased from <b>25 NOVEMBER 79</b> to <b>25/NOV 79</b> , that (I) (we) last saw the deceased alive on <b>25 NOVEMBER 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Teresa Wright</b>				DEGREE <b>BM BCH BA</b>				22c. DATE SIGNED <b>11/25/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TERESA WRIGHT</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL, BALTIMORE</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>		23d. LOCATION CITY OR TOWN <b>Brighton, Mass.</b>		STATE	
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b> 4905 York Road Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>R. J. H. Brady</b>			

BP

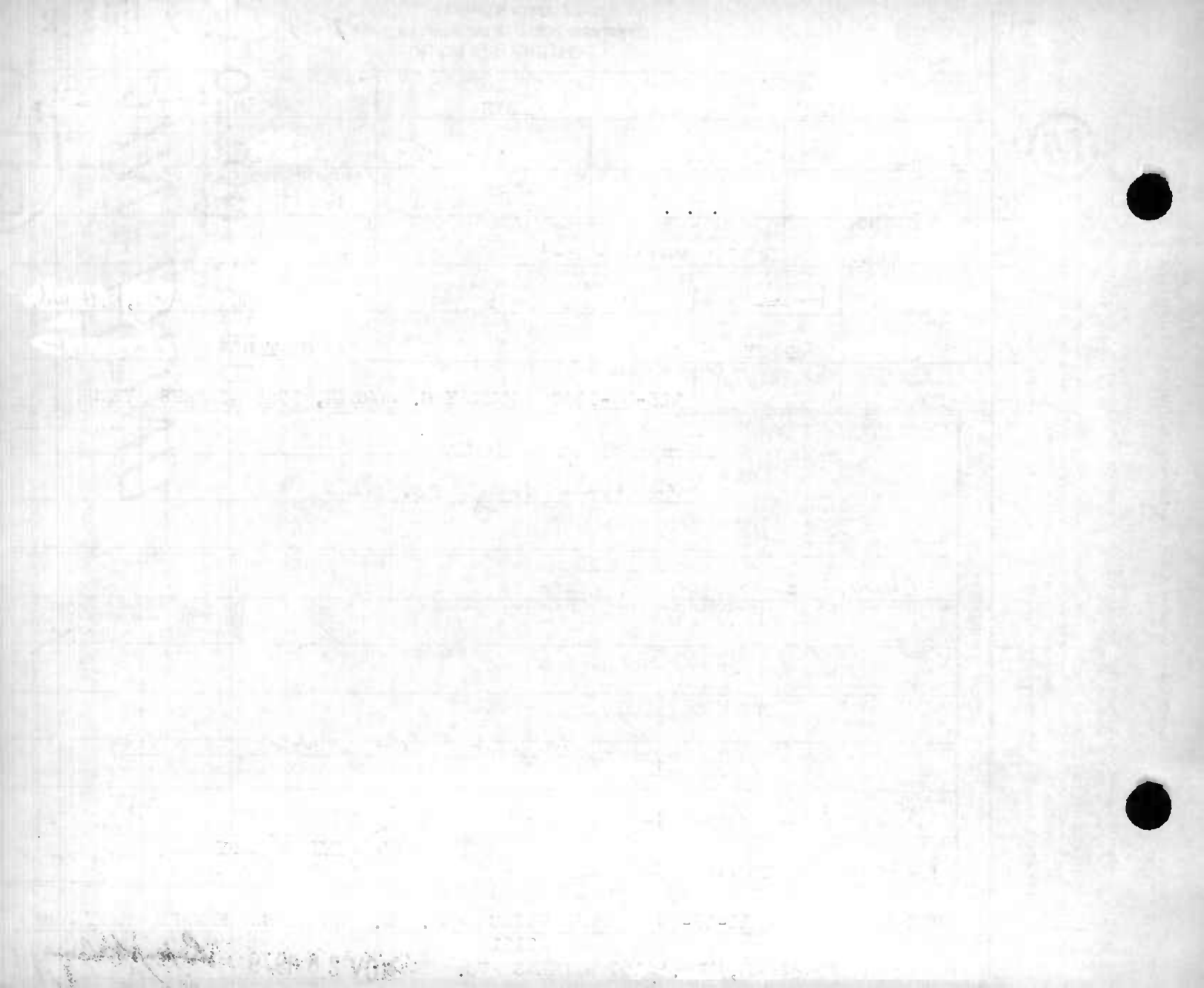


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
IRMA		MARIE		CORBIN		Nov. 26, 79		1203 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		01 24 34		45 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				Balt. City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		3909 Wilkens Ave				HOMEMAKER			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		--		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3909 WILKENS AVENUE, 21229	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
JOHN HENRY REINHOLD		MARY GERTRUDE LAMBDIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		215-30-1490		WESLEY G. CORBIN, 3909 WILKENS AVENUE					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>metastatic lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Chronic pulmonary disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>August 29</u> , 19 <u>79</u> , to <u>Nov. 26</u> , 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>Nov. 13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Robert E. Gallagher, M.D.</u>								<u>11/26/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<u>Robert E. Gallagher</u>		<u>UNIVERSITY OF MARYLAND Baltimore Cancer Research Program</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		11-29-79		MEADOWRIDGE MEM. PK.		ELKRIDGE HOWARD MARYLAND			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE.		21229		NOV 28 1979		<u>Robert E. Gallagher</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 3 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BERNARD J. CORCORAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 16, 79</b>			2b. HOUR <b>10:55A</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 1, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>YRS.</b>	
7a. BIRTHPLACE (COUNTRY) <b>Ireland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Baltimore Catonsville</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>521 Hilton Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Corcoran</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Conlon</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>219-54-3701</b>		17. INFORMANT <b>521 Hilton Ave. - Catonsville, Md. 21228</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4392</b> DUE TO, OR AS A CONSEQUENCE OF <b>20 ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Oct 29 79 to Nov 16 79</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 29 79</b> to <b>Nov 16 79</b> , that (I) (we) lost saw the deceased alive on <b>Nov 16 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Kuang-ya Huang M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>11/16/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUANG KUANG-YA</b>				22e. ADDRESS <b>BON Secours Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/19/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery - Baltimore Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Sterling Funeral Estate</b>				ADDRESS <b>736 Edmondson Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
Catonsville, Md. 21228									

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 3 4			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Thelma M. CORNISH</b>			2a. DATE OF DEATH <b>November 3, 1979</b>		2b. HOUR <b>6:10P M</b>		
3 SEX <b>Female</b>	4 RACE <b>Negro</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>24</b> YEAR <b>1930</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2034 Cliftwood Avenue</b>		
14 FATHER'S NAME FIRST <b>Abell</b> MIDDLE <b></b> LAST <b>Boston</b>			15 MOTHER'S MAIDEN NAME FIRST <b>Nancy</b> MIDDLE <b></b> LAST <b>Singleton</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO <b>220-22-1432</b>		17 INFORMANT ADDRESS <b>Theodore Cornish 2034 Cliftwood Avenue</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain swelling</b> <b>4321</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Subdural hematoma, left frontal, chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic renal failure</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 29, 1979</b> , to <b>November 3, 1979</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>November 3, 1979</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Susan Schwartz</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11-3-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Susan Schwartz, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/9/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION CITY OR TOWN <b>Arbutus, Maryland</b> COUNTY STATE	
24 FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				ADDRESS <b>1101 East North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 6 1979</b>	
				25b. REGISTRAR'S SIGNATURE <i>Patricia McCreedy</i>			

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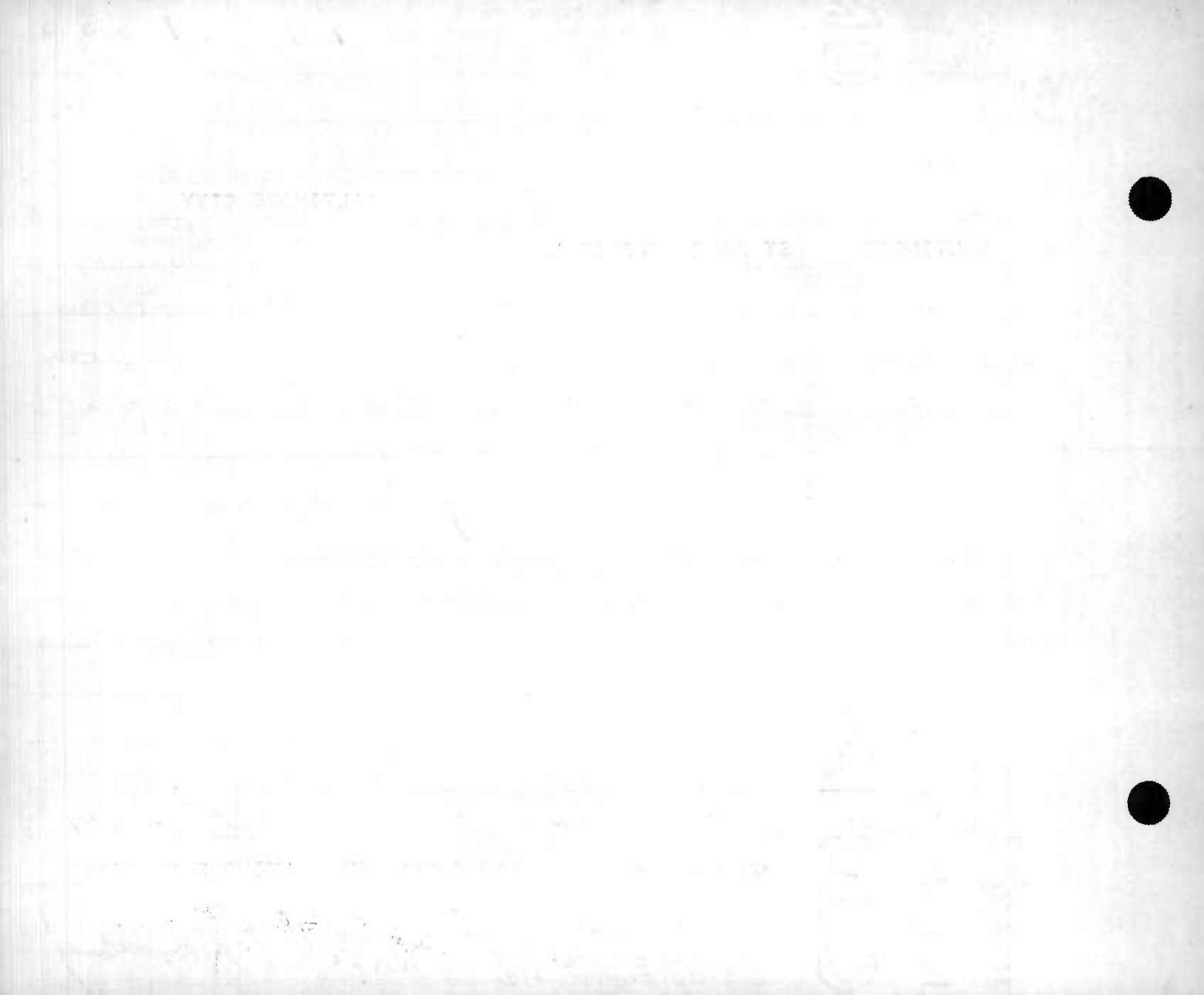


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 3 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Theodore Ernest Coronis</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>11 - 10 - 79</i>				2b. HOUR <i>4:05</i> P.M.			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 17 1914</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Greece</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Salesman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Paper Supply</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>232 Stonecroft Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ernest Coronis</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Pelagia Tsigareu</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes WWII</i>				16b. SOCIAL SECURITY NO. <i>269-11-8596</i>		17. INFORMANT ADDRESS <i>Mrs. Wanda Cornis 232 Stonecroft Rd, Baltimore Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Arrest</i> <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Squamous Cell Ca of lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>VS</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dennis M. Smith</i>				DEGREE <i>M.D.</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/10/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DENNIS M. SMITH MD.</i>				22e. ADDRESS <i>900 CATON AVE BALTIMORE MD 21229</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>11-12-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greek Orthodox Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Baltimore Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Nicholas T. Matthews, 3021 Eastern Ave. Baltimore, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 14 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO "THE FUNERAL DIRECTOR" AND PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Rachele Cortese</b>		2a. DATE OF DEATH KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>11 5 1979</b>		2b. HOUR <b>5:24 A</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 19 01</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3418 E. Pratt Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>
12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS <b>3418 E. Pratt Street</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Felice A. Cerchiaro</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Finita Fragiacomio</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-03-3733 D</b>		17. INFORMANT ADDRESS <b>Mr. Saverio Cortese</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH .
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Virginia L. Dolan M.D.</b>		TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>11/6/79</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/9/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Zannino Funeral Home, 263 S. Conkling St.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 7 9 2 7 2 3 7							
1. DECEASED NAME (TYPE OR PRINT) VINCENT J. CORTIS			2a. DATE OF DEATH NOVEMBER 13, 1979			2b. HOUR 8:36AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 11, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 411 N. Curley Street	
14. FATHER'S NAME FIRST MIDDLE LAST Salvatore Cortis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Teresia LaCava							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Baltimore, Maryland, 21224. Mrs. Anna M. Cortis- 411 N. Curley St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC LUNG DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>GASTROINTESTINAL BLEEDING; DIABETES MELLITUS</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>10-6-</u> <u>19 79</u> , to <u>11-13-</u> <u>19 79</u> , that (1) we just saw the deceased alive on <u>11-13-</u> <u>19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>A. F. Nazemi M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/27-37-79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. F. NAZEMI, M.D.						22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD 21231				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/16/79		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem. - Baltimore			23d. LOCATION CITY OR TOWN COUNTY STATE Maryland		
24. FUNERAL DIRECTOR NAME John A. Moran, Inc. 3000 E. Baltimore St.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 2 3 8	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST JAMES M COSTLEY			2a. DATE OF DEATH MONTH DAY YEAR 11/5/79			2b. HOUR 10:02 PM		
3. SEX M		4. RACE E		5. DATE OF BIRTH MONTH DAY YEAR 4 8 05		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 6 27		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED - Chauffeur			12b. KIND OF BUSINESS OR INDUSTRY LUDILM IND.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY CARROLL				13c. CITY OR TOWN NEW WINDSOR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3801 ROOP ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST James Costley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Costley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 173-20-3815		17. INFORMANT ADDRESS Dorothy M. Costley, Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 410 - DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) GASTROINTESTINAL BLEEDING; HISTIOCYTIC LYMPHOMA											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 10/29 19 79 to 11/5 19 79, that (I) (we) lost saw the deceased alive on 11/5 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.											
22b. SIGNATURE Evelyn Jackson, MD.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/5/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVELYN JACKSON, MD.						22e. ADDRESS 22 S GREENE ST. BALT. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-9-1979		23c. NAME OF CEMETERY OR CREMATORY Fairview			23d. LOCATION CITY OR TOWN COUNTY STATE Carroll, Md.			
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr.,						ADDRESS Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR NOV 8 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5. FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST ARIADNE		MIDDLE COULIANOS		LAST COULIANOS		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11 21 1979		7b. HOUR 5:45 P.M.	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 4 3 52	6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 11 21 1979		2d. HOUR 5:45 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5730 Nasco Pl.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5730 Nasco Place			
14. FATHER'S NAME FIRST MIDDLE LAST Michael Coulianos				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Katsimbri							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 212-60-9505		16c. INFORMANT'S NAME AND ADDRESS Michael Coulianos, 1801 Charles Street Newport Ritchie, Fla. 33552					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stab wounds of chest</u> 966- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 11-21-1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject stabbed.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5730 Nasco Pl. Balto. Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 		M.D. Assistant				MEDICAL EXAMINER		DATE SIGNED 11-22-79			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-24-79		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.			
24. FUNERAL DIRECTOR NAME Nicholas T. Matthews, ADDRESS 3021 Eastern Ave., Balto		25a. DATE REC'D. BY REGISTRAR NOV 27 1979		25b. REGISTRAR'S SIGNATURE 							

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

FOR THE

OF

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 4 0

REG. NO.

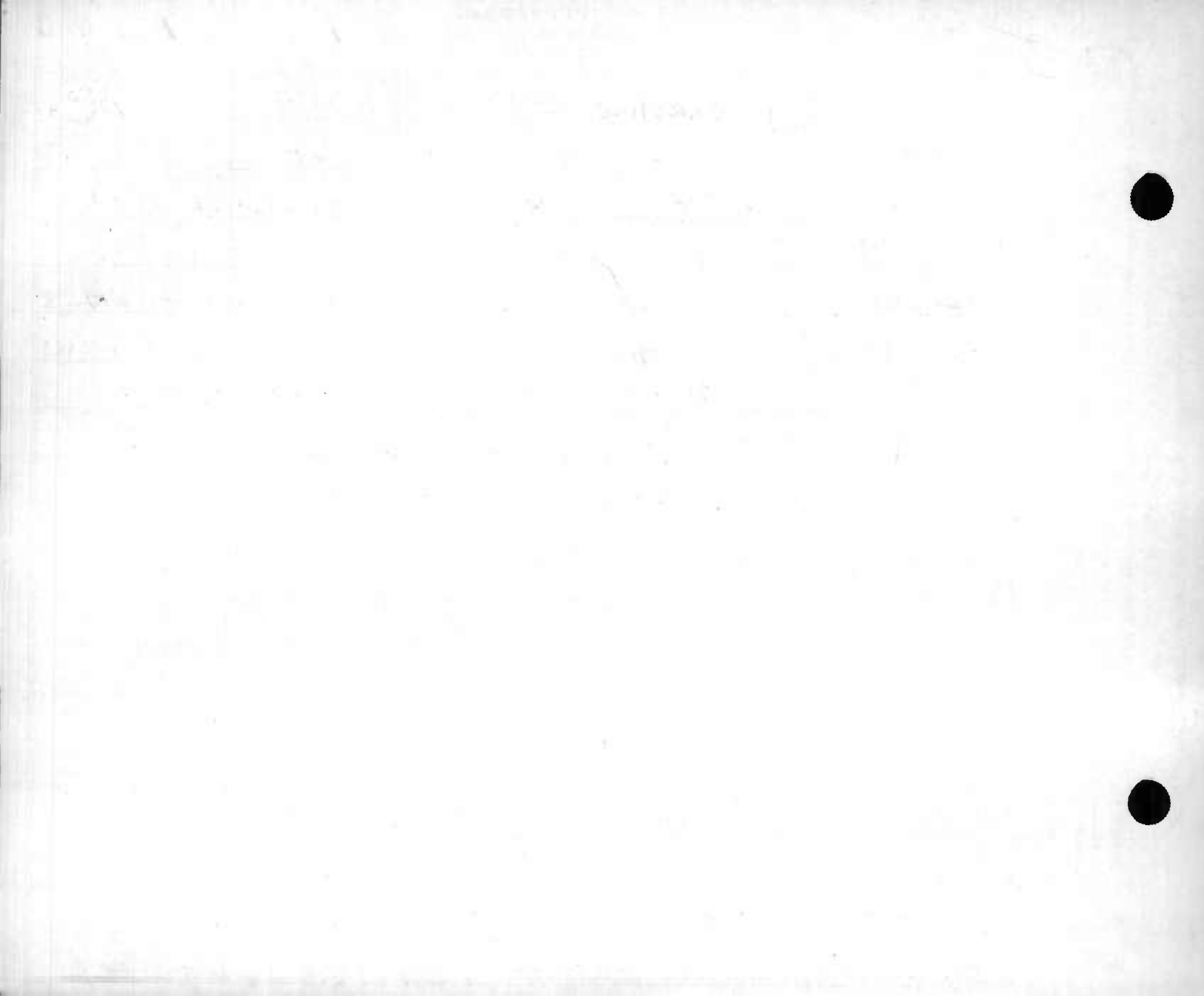
1. DECEASED NAME (TYPE OR PRINT) <b>COURTNEY, CAROLINE GUY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/22/79</b>		2b. HOUR <b>1230</b> AM						
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 30 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTO. MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALT. MD.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>2114 W. FAYETTE ST. 21223</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE HANDY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HARRIET DOUGLASS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>216-18-7433</b>		17. INFORMANT ADDRESS <b>Venus Jackson 504 North Carrollton Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of left lung</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-18</b> , 19 <b>79</b> , to <b>11-22</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11-21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Robert B. McDaniel</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-22-79.</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert B. McDaniel</b>						22e. ADDRESS <b>Bon Secours Hospital.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/ 26/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Freedman AMUP Ch.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Tyaskin, Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 East North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Petryhelovsky</b>			

MEDICAL CERTIFICATION

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 4 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Cornelius C. COVINGTON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 19 1979</b>				2b. HOUR <b>6:25A M</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 19, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
12. CITY OR TOWN OF DEATH <b>Baltimore</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Western Electric</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Pipe Fitter</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Ruley Covington</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elmira Sewell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO <b>216 03 2094</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret I. Covington same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>4349</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Valvular Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 21</b> , 19 <b>79</b> , to <b>November 19</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 19</b> , 19 <b>79</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Harry E. Nervino, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>11-19-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harry S. Nervino, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemety</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruek, Inc.</b>				ADDRESS <b>5305 Harford Road</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		REGISTRAR'S SIGNATURE <b>Harry E. Nervino</b>	

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c/o Maryland General Hospital

Harry S. Levinson, M.D.

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NOV 14 1979

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9 2 7 2 4 2  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Claude Coward</i>			2a. DATE OF DEATH MONTH <i>11</i> DAY <i>1</i> YEAR <i>79</i>		2b. HOUR <i>2:30</i> AM
3. SEX <i>male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH <i>11</i> DAY <i>6</i> YEAR <i>01</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			10. CITY OR TOWN OF DEATH <i>Baltimore</i>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>		
13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <i>3810 Egerton Road</i>			14. FATHER'S NAME FIRST <i>William</i> MIDDLE <i>Coward</i> LAST <i>Coward</i>		
15. MOTHER'S MAIDEN NAME FIRST <i>Marenda</i> MIDDLE <i>Dawson</i> LAST <i>Dawson</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		
16b. SOCIAL SECURITY NO. <i>No</i>			17. INFORMANT ADDRESS <i>Kathleen Wilson 3810 Egerton Road</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>4280 Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4280</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/17</i> 19 <i>79</i> , to <i>11/1</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>11/1</i> 19 <i>79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Arnold Falchbrook</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>10/1/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ARNOLD FALCHBROOK</i>		22e. ADDRESS <i>BALT. CITY HOSP., BALT. MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/2/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King Memorial Park</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Co., Maryland</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>Wm. C. March F/H 1101 East North Ave.</i>			
25a. DATE REC'D. BY REGISTRAR <i>NOV 2 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert H. Bundy</i>			

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Lois A. Cox</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>18</b> YEAR <b>79</b>			2b. HOUR <b>M</b>	
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>15</b> YEAR <b>35</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1305 E. North Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>	
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>W.</b> LAST <b>Powell</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Rose</b> MIDDLE <b>Freehart</b> LAST <b>Freehart</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Peggy Powell</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>squamous carcinoma prob. esophagus.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>several months</b> <b>several months</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>anemia</b> <b>several months</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-7-79</b> to <b>11-18-79</b> , that (I) (we) lost saw the deceased alive on <b>11-18-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>E. Ellsworth Code</b> MD				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore Co., Md.</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia A. Brady</b>	

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DEPT. OF AGRICULTURE

WATER



U. S. DEPT. OF AGRICULTURE

U. S. DEPT. OF AGRICULTURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF VITAL RECORDS CASE, PAGE 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 9 27244	
1. DECEASED NAME (TYPE OR PRINT) <b>FRANK D. CRAWFORD</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>21</b> YEAR <b>1979</b>		2b. HOUR <b>M</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>90 YRS.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>11 21 1979</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2120 St. Paul St.</b>				9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Baltimore City</b> MD.			
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2120 St. Paul St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>429.2</b> } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Ann M. Dixon, M.D.</b>				TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>11-22-79</b>			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>11/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony R. Brady</b>			



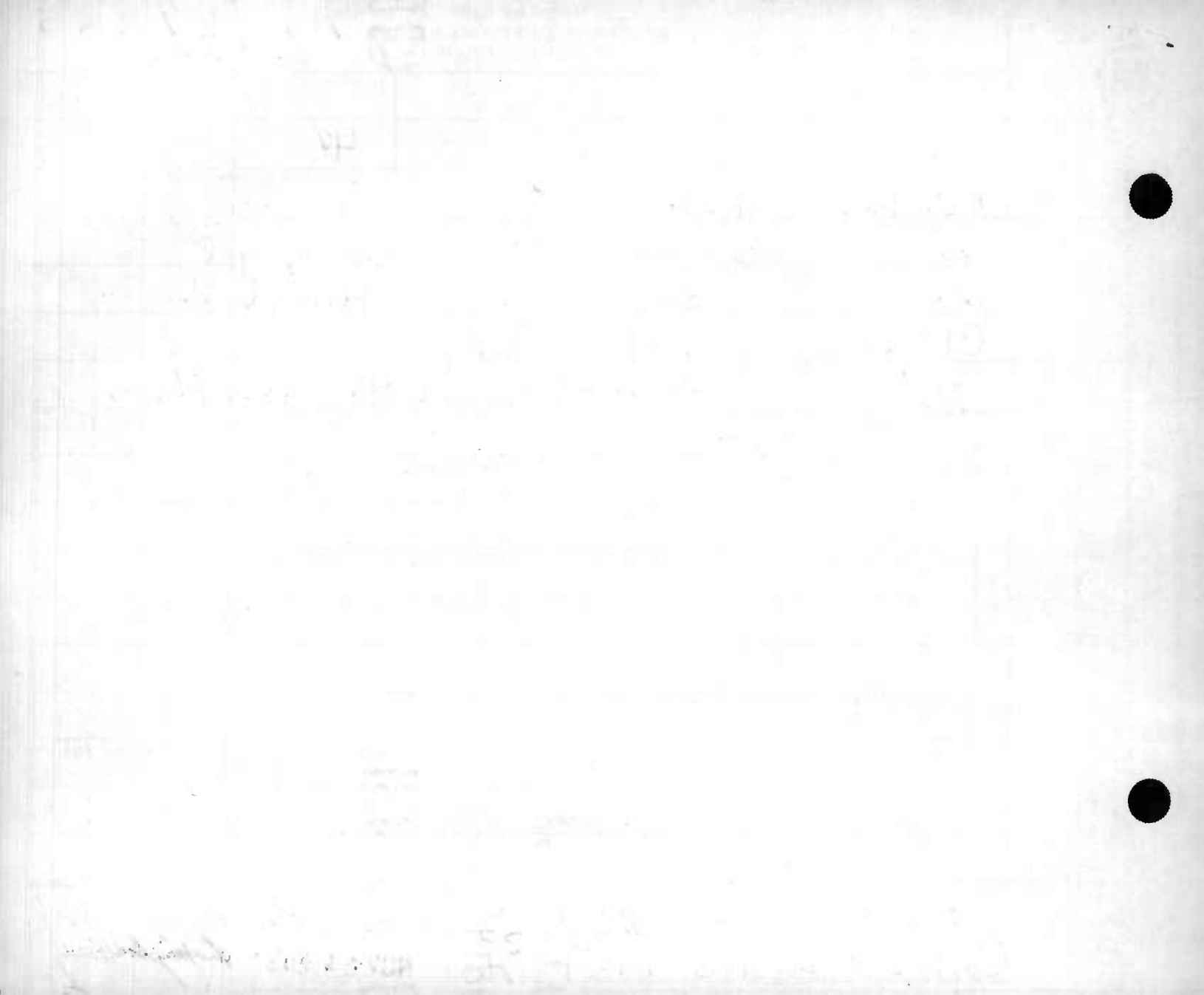


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 27 24 5			
1. FOR STATE REGISTRAR				REG. NO. 1002-2			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILTON CREDLE			2a. DATE OF DEATH MONTH DAY YEAR 11-19-79		2b. HOUR 2:40A.M.		
3. SEX male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 04 11 1930		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		12b. KIND OF BUSINESS OR INDUSTRY	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed		13a. STREET ADDRESS Harford Rd.		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Claude Credle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dolly Wilson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, MO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-22-4237	
17. INFORMANT ADDRESS Gloria Little 3525 Flannery La.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5715 Upper G.F. Bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal Varices DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of the Liver APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 hrs. years years		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from Nov 17, 1979, to Nov 19, 1979, that (I) (we) lost saw the deceased alive on Nov 19, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Yonel		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Nov 19, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yonel		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-24-79		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cems.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Md.	
24. FUNERAL DIRECTOR NAME Carlton C. Douglass		ADDRESS 1012 Penn Ave		25. DATE REC'D. BY REGISTRAR NOV 21 1979		25b. REGISTRAR'S SIGNATURE Rafael McCreedy	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 4 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MADLINE</b> <b>CRIM</b>				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
MADLINE <b>CRIM</b> (CRIM)				NOVEMBER 8, 1979 8:40 P.M.			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 11, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WORK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MD.</b> 13b. COUNTY <b>-----</b> 13c. CITY OR TOWN <b>BALTIMORE</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>3302 FAIT AVE. # 21224.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>AUGUSTUS W. KAPPEL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BARBARA CURRAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO <b>220-18-4522</b>		17. INFORMANT ADDRESS <b>626 SEQUOIA DRIVE. EDGEWOOD, 21040, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Cervix</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>-----</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>-----</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>11/8/79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>11/7/79</b> 19 <b>79</b> , to <b>11/8</b> 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>11/8</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ross Jacobson</b> M.D. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/8/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ross Jacobson</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-12-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FIRST UNITED EVAN.CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>6115 O'DONNELL ST., BALTO., MD.</b>	
24. FUNERAL DIRECTOR, NAME <b>Charles S. Seiler &amp; Son, Inc.</b>		901 S. CONKLING ST. BALTO., 21224, MD.		25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP







1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 4 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George Crippens, Jr.</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>23</b> YEAR <b>79</b>			2b. HOUR <b>M</b>					
3 SEX <b>M</b>		4 RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>26</b> YEAR <b>12</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1521 N. Wolfe St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1521 N. Wolfe St.</b>			
14. FATHER'S NAME FIRST <b>George</b> MIDDLE LAST <b>Crippens</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mannie</b> MIDDLE LAST <b>Drummer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO <b>216-18-8548</b>		17. INFORMANT <b>Mary Crippens</b>		ADDRESS <b>1521 N. Wolfe St.</b>			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>185- respiratory arrest.</b> IMMEDIATE CAUSE (a) <b>respiratory arrest.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>metastatic prostatic cancer -</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>none -</b>							
19a. DATE OF OPERATION <b>none -</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A.</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>July 1, 1979</b> to <b>Nov 6, 1979</b> , that (1) (we) last saw the deceased alive on <b>Nov 6, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>above (1) (we) did not view the body after death.</b>							
22b. SIGNATURE <b>Leroy M. Nyberg</b> M.D.				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/26/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leroy M. Nyberg, M.D., Jr.</b>				22e. ADDRESS <b>Johns Hopkins Hospital Baltimore, Maryland 21205</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore, Md.</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Leroy M. Nyberg</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STANDARD TIME



13/12

13/12

10/10

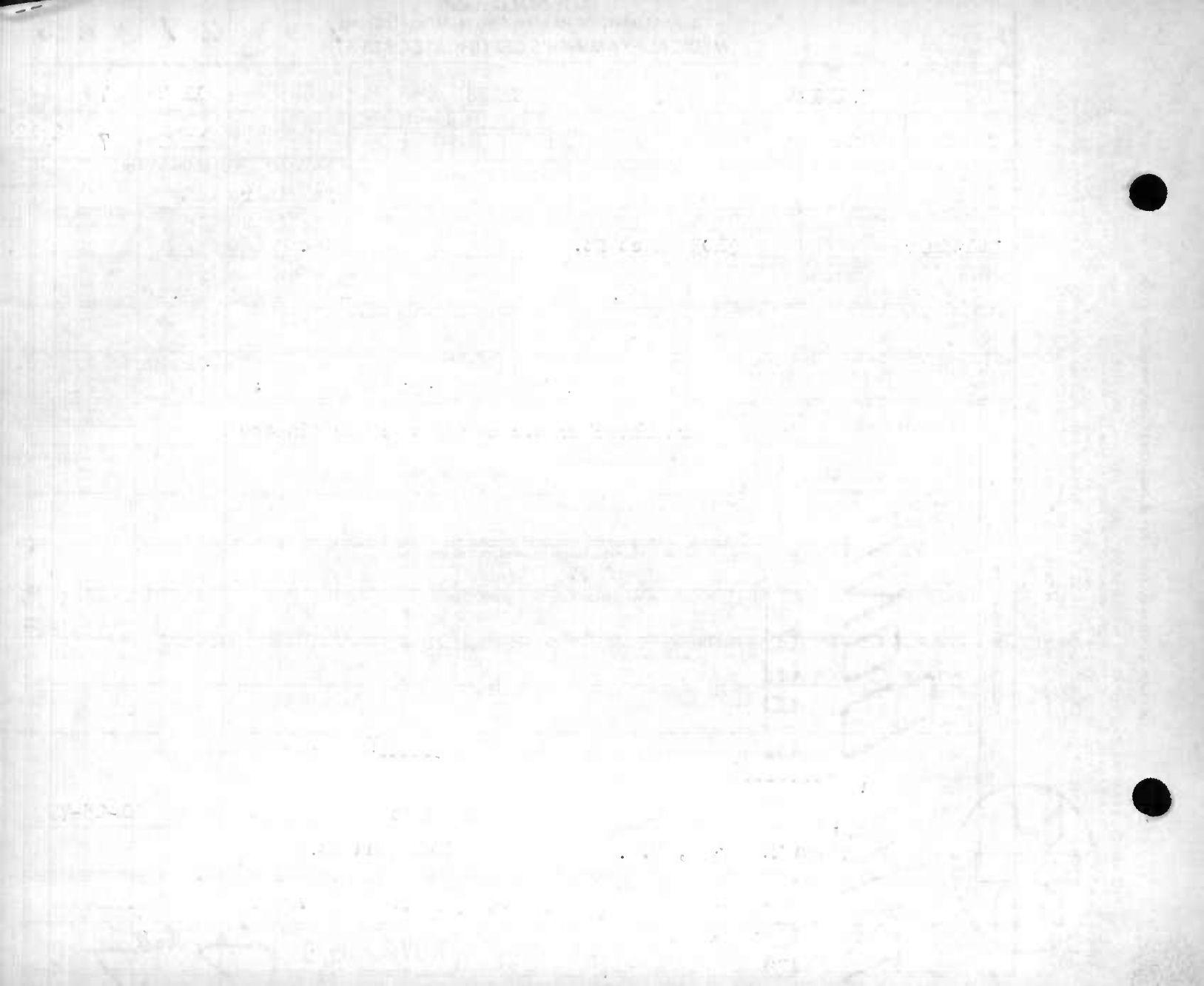
13/12

REG. NO.

## MEDICAL CERTIFICATION

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

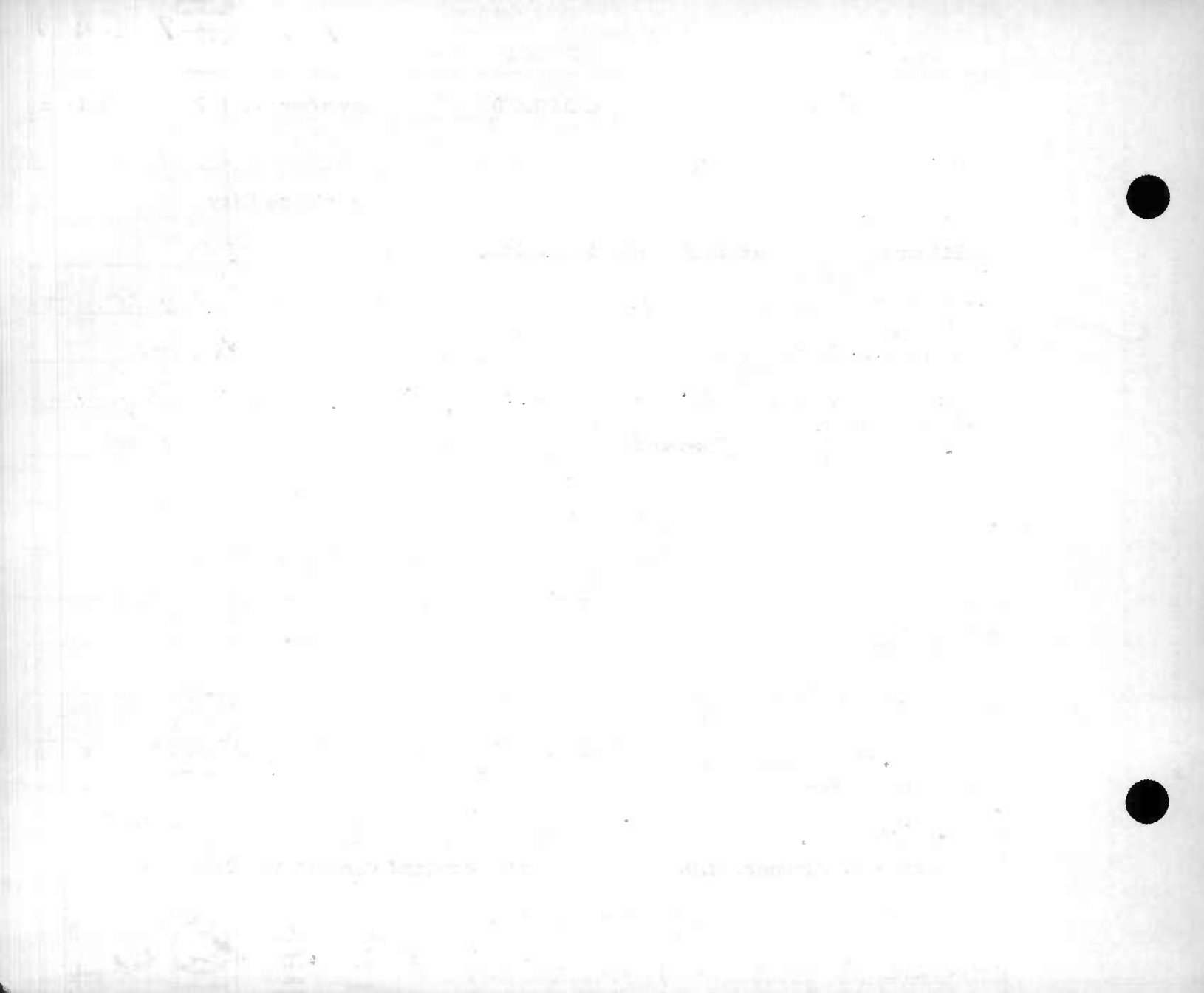


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 2 4 9	
FOR 1 - STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
James			CROSSLAND			November 3, 1979			2:14 a.m.		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
MALE		Negro		1-28-21		58 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
77 MULLIN/SC.		U.S.A.									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Maryland General Hospital				Retired Truck Driver					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND			BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS		
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
UNKNOWN			Jessie MCRAE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17 INFORMANT			ADDRESS		
Yes			WWII			Gregory J. Crossland			appt. FB. 912 BELGIAN AVE		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Week	
486- Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last. (b) _____ (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <del>XX</del> this hospital attended the deceased from <u>October 27</u> , 19 <u>79</u> , to <u>November 3</u> , 19 <u>79</u> , that <del>(X)</del> (we) lost saw the deceased alive on <u>November 3</u> , 19 <u>79</u> , and that in <del>(XX)</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>(X)</del> (we) (did) <del>(XX)</del> (not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
Harvey S. Mishner M.D.									11-5-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Harvey S. Mishner, M.D.			c/o Maryland General Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			11-9-79		Mt. Calvary Cemetery			ANNE ARUNDEL COUNTY			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William J. Spier			1639 N. Broadway			NOV 7 1979		Richard A. Bandy			





1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 5 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) WALTER B. CRUMP			2a DATE OF DEATH MONTH DAY YEAR 11/23/79			2b HOUR 5:20 P.M.			
3 SEX M		4 RACE N		5 DATE OF BIRTH MONTH DAY YEAR 1/16/18		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.			13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME Walter			15. MOTHER'S MAIDEN NAME Lulla Bridges			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes			
16b SOCIAL SECURITY NO. 4149			17 INFORMANT Ora Belle Crump			17 ADDRESS 3301 Ingleside Ave.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Congestive Heart Failure 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ② Hypertensive Heart Disease (c) ③ Coronary Artery Disease. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from November 15/79 3/8 1978 to present time, that (I) (we) last saw the deceased alive on November 15/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sukuba			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-26-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) O. SUKUBA			22e. ADDRESS 600 Reisterstown Rd						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/29/79		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Naltimore Co., Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/H					ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR NOV 29 1979		25b. REGISTRAR'S SIGNATURE Ruthy McCreedy

70 42 35 300 1

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

GOSS COALTON FIBER

PAULET VALLEY



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH		2b. HOUR							
FIRST MIDDLE LAST Russell Welch Cuppett Jr.										DATE KNOWN OF DEATH 11 5 19 79		HOUR M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Male		White		7 19 1923		56 YRS.		MONTHS DAYS		HOURS MIN		11 5 19 79		P M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
West Virginia				U.S.A.								Baltimore City, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				South Baltimore General Hospital								Machinist				BOSTON Dye			
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.										Anne Arundel		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rte. 3 Box 457 A			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Russell Welch Cuppett Sr.										FIRST MIDDLE LAST Bertha Waters									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
No										235-22-1741					Yvonne Dove 715 205 th St. Pasadena, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?			
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Virginia L. Dolan				Assistant				11/6/79											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Virginia L. Dolan, M.D.				111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				11/8/1979				Meadowridge Mem. Park				Donsey, Howard Co. Md.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
McCully F.H.				Pasadena, Mountain & Tick Neck Rds.				NOV 14 1979				R. J. McCully							

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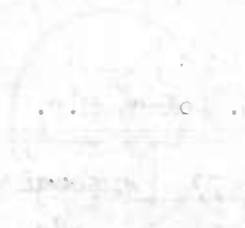
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with 572-5000 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 5 2			
1. FOR STATE REGISTRAR				REG. NO.			
2. DECEASED NAME (TYPE OR PRINT) <b>ELLEN L. DANGLE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 20, 1979</b>		2b. HOUR <b>9:15A</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 28, 1930</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>49</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10 CITY OR TOWN OF DEATH <b>Balto.</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>P. G</b> 13c. CITY OR TOWN <b>College Park</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>7607 Charlton Ave.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Lawrence Lancashire</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elda Hayden</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Eugene L. Dangle 7607 Charlton Ave. College Park 20740</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2030 MULTIPLE MYELOMA WITH MYELOFIBROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 YRS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/22</b> , 19 <b>79</b> , to <b>11/20</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/20</b> , 19 <b>79</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE <b>E. L. Sullivan MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-20-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 21, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Md.</b>	
24 FUNERAL DIRECTOR NAME <b>G. Truman Schwab</b>				24b. ADDRESS <b>3512 Frederick Ave. Balto. Md. 21229</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1979</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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Information Nov. 21, 1972  
5512 Frederick Ave.  
Catonville, Ga.

Nov. 21, 1972



FOR  
1- STATE  
REGISTRAR

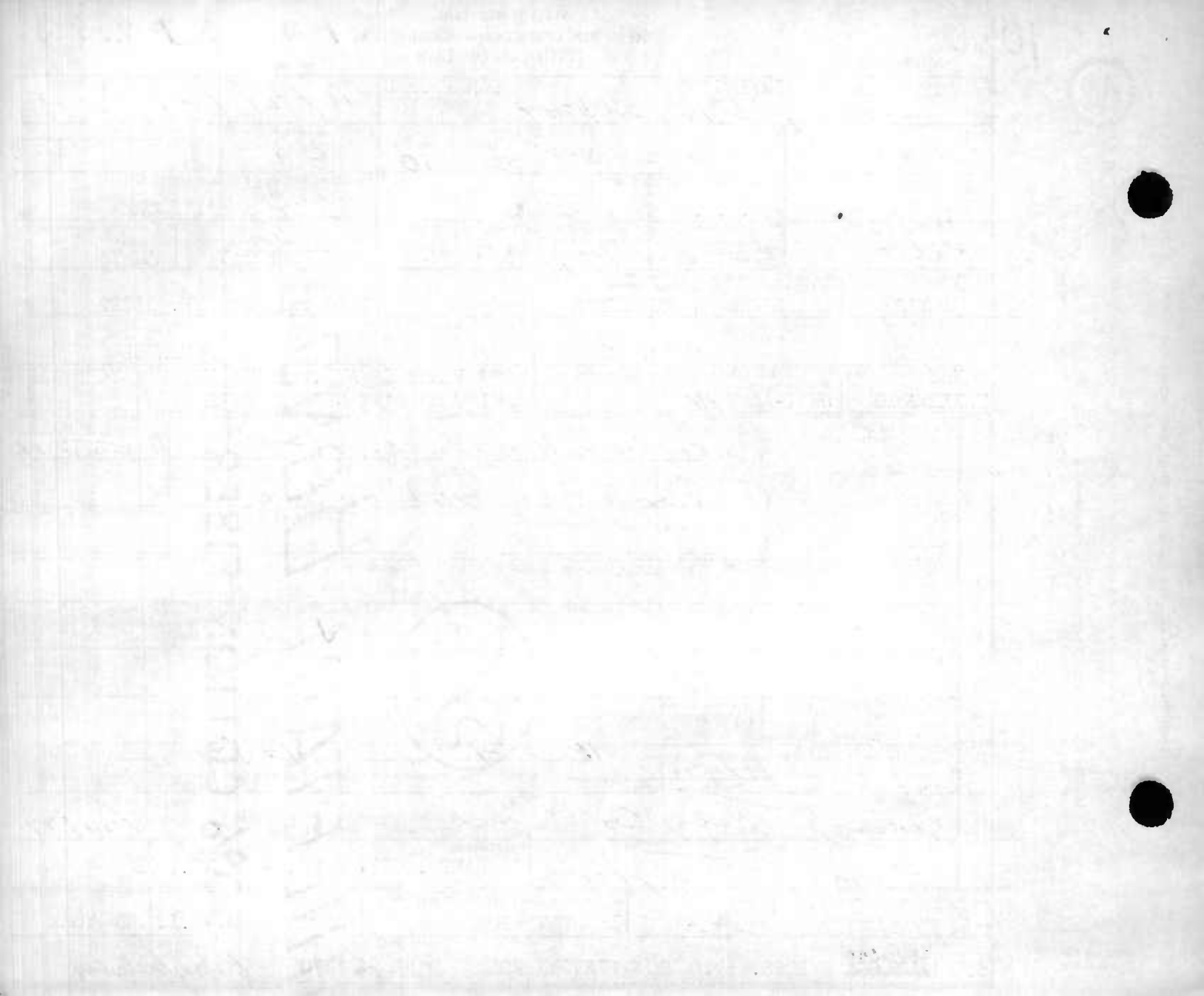
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IRVING DANNENBERG</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/21/79</b>		2b. HOUR <b>5:55</b> M
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 30 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <del>XXXXXX</del> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY BALTIMORE</b> MD.
10. CITY OR TOWN OF DEATH <b>Balto</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto City Hospitals</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>US GOVERNMENT</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>ARMY</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACOB DANNENBERG</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SELMA SCHENDEL</b>		
16a. YES DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO XXXXX</b>		16b. SOCIAL SECURITY NO. <b>WWII-ARMY A/E</b>		17. HOME ADDRESS <b>1901 FLATBUSH AVE. BROOKLYN, NEW YORK 11210</b> <b>BOULEVARD PARK WEST CHAPELS</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b> <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF, (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 min of CPR</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):				
19a. DATE OF OPERATION <b>11/21/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>11/12/79</b> , 19____, to <b>11/21/79</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/21/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Henry Taylor</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/21/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry Taylor</b>		22e. ADDRESS <b>BALTO. CITY HOSP. - BALTO., MD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL/BURIAL</b>		23b. DATE <b>11-25-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW MONTEFIORE</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>FARMINGDALE, L.I. NEW YORK</b>				
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>
25b. REGISTRAR'S SIGNATURE <b>Lispy Kelly</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 5 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EMMETT FRANKLIN Danner				2a. DATE OF DEATH 11-18-79		2b. HOUR 3:15 P.M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH Feb 14, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elect. Supv.		12b. KIND OF BUSINESS OR INDUSTRY G.S.A.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY A.A. Co.		13c. CITY OR TOWN Riviera Bch	
14. FATHER'S NAME 14a. FIRST Harry 14b. MIDDLE L. 14c. LAST Danner				15. MOTHER'S MAIDEN NAME 15a. FIRST Lucy 15b. MIDDLE Marguerite 15c. LAST Nash			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. II 219 14 8780		17. INFORMANT ADDRESS Alice M. Danner same as 13 e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart Failure Pulm. Congestion</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 16</u> 19 <u>79</u> to <u>Nov 18</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Nov 18</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <u>E. Myers</u>				DEGREE		22c. DATE SIGNED	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) EVA MYERS M.D.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/21/79		23c. NAME OF CEMETERY OR CREMATORY Park Heights Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Brunswick Md.	
24. FUNERAL DIRECTOR NAME George J. Gonce 4001 Ritchie Hgwy				25a. DATE REC'D. BY REGISTRAR NOV 23 1979		25b. REGISTRAR'S SIGNATURE <u>Robert Kennedy</u>	

WILD





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 in retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2717 BP  
DHMH-16 50M/7/77  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 27255	
FOR 1. STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>COORON H. DARKS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11 24 79</b>		2b. HOUR <b>6:58 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 1 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY						13c. CITY OR TOWN <b>BALTIMORE</b>		13d. STREET ADDRESS <b>4852 Pimlico Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unkn</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unkn</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-16-2033</b>		17. INFORMANT ADDRESS <b>MARY Mitchell 4852 Pimlico Road</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>2396</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brain tumor</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Possible metastatic disease</b>											
19a. DATE OF OPERATION <b>?</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>?</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>10/8</b> 19 <b>79</b> to <b>11/24</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/23</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Gabaldoni</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/24/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LOUIS J. GABALDONI</b>				22e. ADDRESS <b>SINAI HOSPITAL, BALTO. MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/29/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				ADDRESS <b>1101 East North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>H. J. M. M. M.</b>			

MEDICAL CERTIFICATION

1941-1942

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

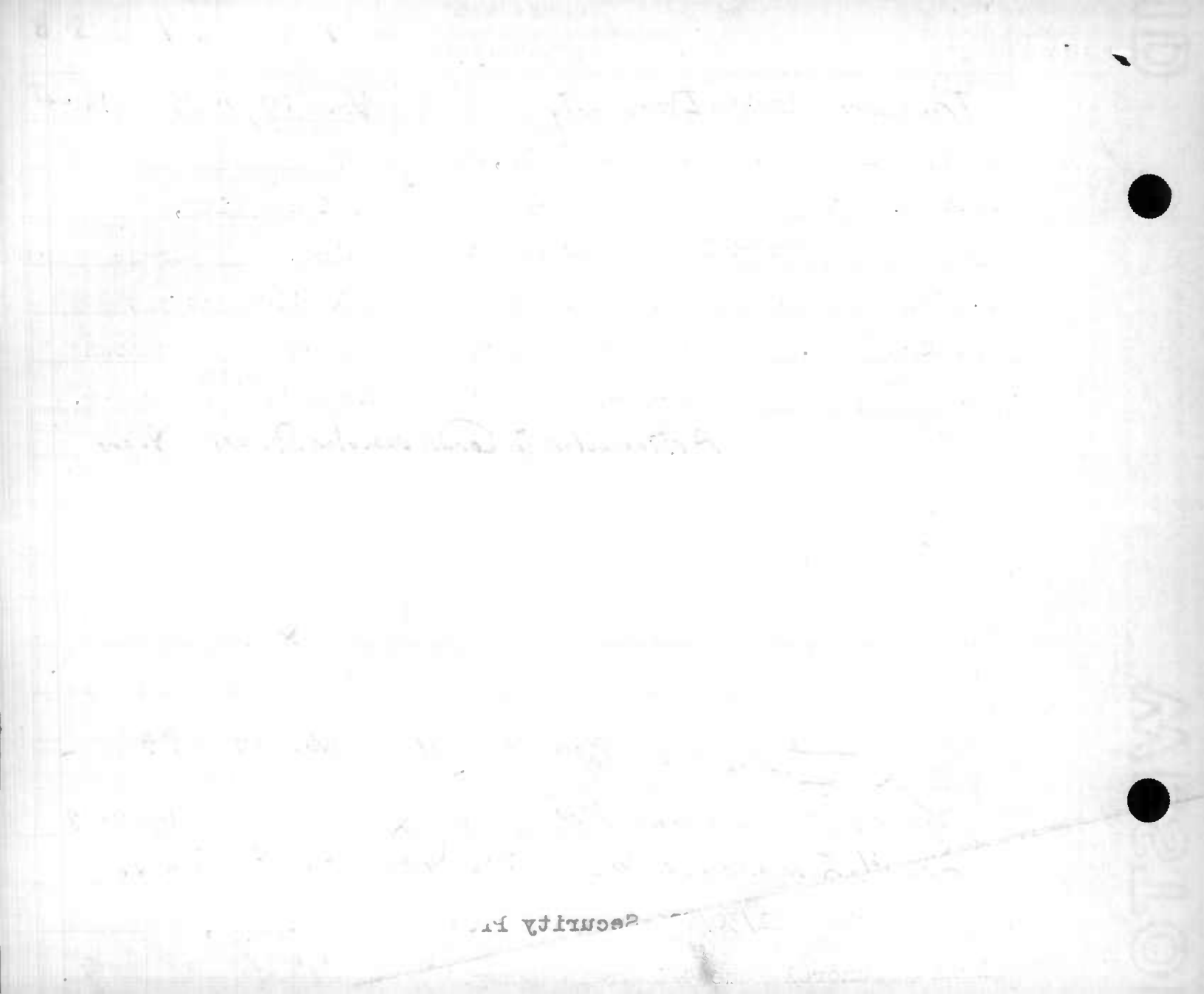
FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 5 6

REG. NO.

1. DECEASED NAME (TYPE OF NAME) Theodore Columbus Daugherty			2a. DATE OF DEATH MONTH DAY YEAR Nov. 27, 1979			2b. HOUR 12:45 <sup>P</sup> <sub>M</sub>				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 10, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		8b. CITIZEN OF WHAT COUNTRY? USA		9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Federal Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Crane Operator		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1312 Light Street	
14. FATHER'S NAME FIRST MIDDLE LAST Charles C. Daugherty			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Maude Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-10-9976		17. INFORMANT ADDRESS Arbutus Raymond Daugherty 1012 Leeds Ave.					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from May 12, 1971, to Nov. 27, 1979, that (I) (the) last saw the deceased alive on Nov. 13, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE Loy M. Zimmerman M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 11/27/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Loy M. Zimmerman M.D.						22e. ADDRESS 3202 Hartford Rd. Baltimore				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 11/30/79		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Maryland			
24. FUNERAL DIRECTOR NAME Kirkley Funeral Home 421 Grain Hwy.						25a. DATE REC'D. BY REGISTRAR DEC 4 1979		25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

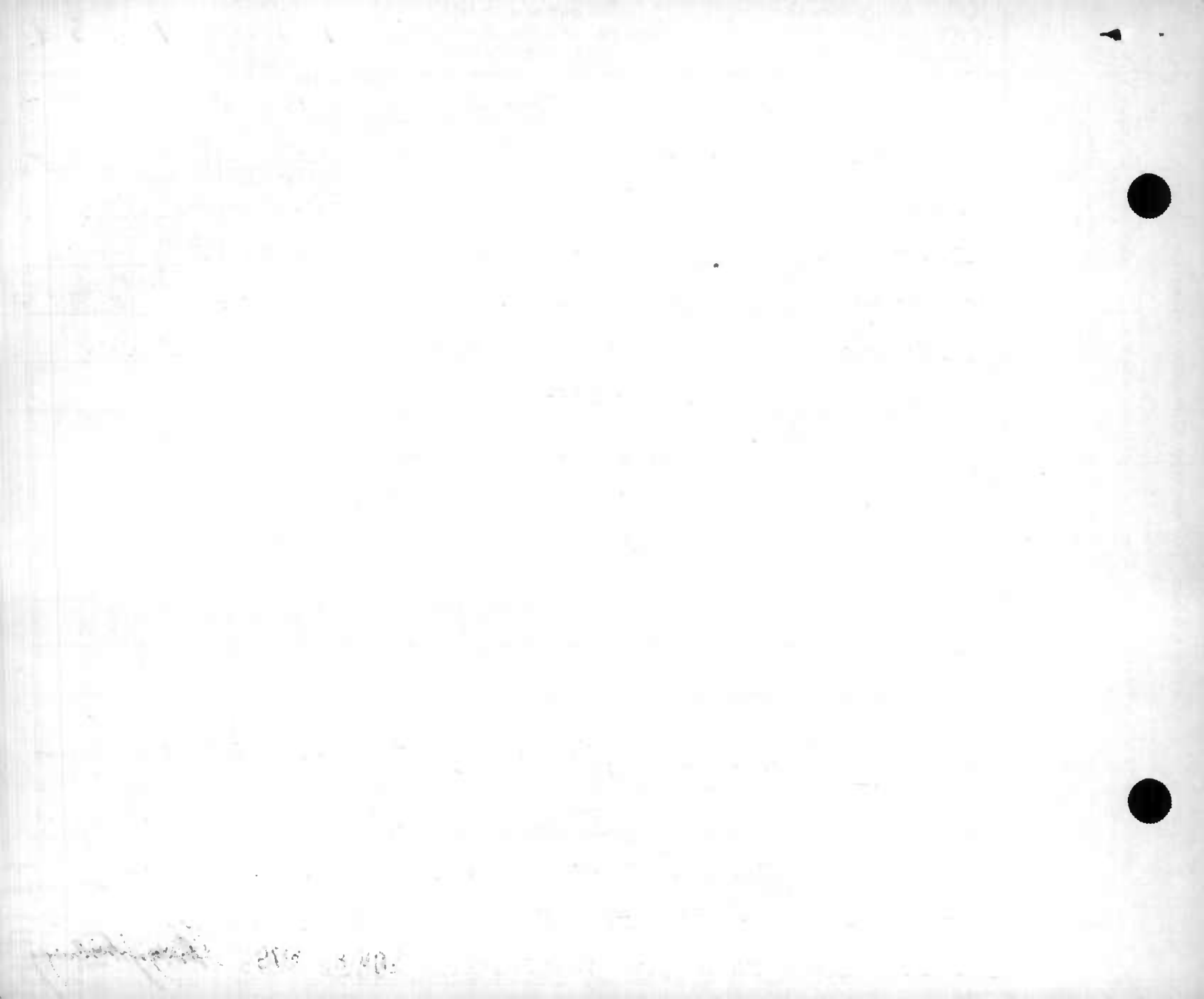
7 9 2 7 2 5 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLAIRE DAVID</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 5 1979</b>			2b. HOUR <b>130A</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 12 1994</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7121 PARK HEIGHTS AVE APT 904</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS STURZ</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNY STARK</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213-74-2554</b>		17. INFORMANT <b>ADDRESS</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b> <b>410 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Longstanding Heart Failure</b> (c) <b>Ac Myocardial Infarction</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>APR 17 1978</b> , to <b>NOV 5 1979</b> , that (I) (we) last saw the deceased alive on <b>NOV 4 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Willard Applefeld MD</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/5/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Willard Applefeld MD</b>						22e. ADDRESS <b>6615 REISTERSTOWN RD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH TALOR</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WOODLAWN BALTO. MD</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSONY BEOS. 6010 REISTERSTOWN</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>			

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



2016 340

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 27258

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Janie Davis</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11/14/79</i>		2b. HOUR <i>12:18 PM</i>		
3. SEX <i>FEMALE</i>		4. RACE <i>BLACK</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 14 12</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>67</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Balto. Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hosp. of Balto.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Public Sch.</i>							
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	
13d. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <i>3504 Fairview Ave.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>UNKNOWN</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Amanda Bowser</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>219-22-7229</i>		17. INFORMANT ADDRESS <i>Mr. Sylistus Bowser 3504 Fairview Av.</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ca of Breast metastatic to Bone + Lung</i>			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION <i>5-77</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Breast ca/Radical Mastectomy</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/7</i> , 19 <i>79</i> , to <i>11/14</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/13/79</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Steven L. Joffe M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>11/14/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Steven L. Joffe M.D.</i>		22e. ADDRESS <i>Sinai Hosp. of Balto.</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-17-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Herbert E. Nutter 3035 W. North Ave.</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 16 1979</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



12-1-40

17-1-40

NOTED - 12-1-40

RECEIVED 12-1-40

12-1-40

12-1-40

12-1-40

12-1-40

12-1-40

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12-1-40



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

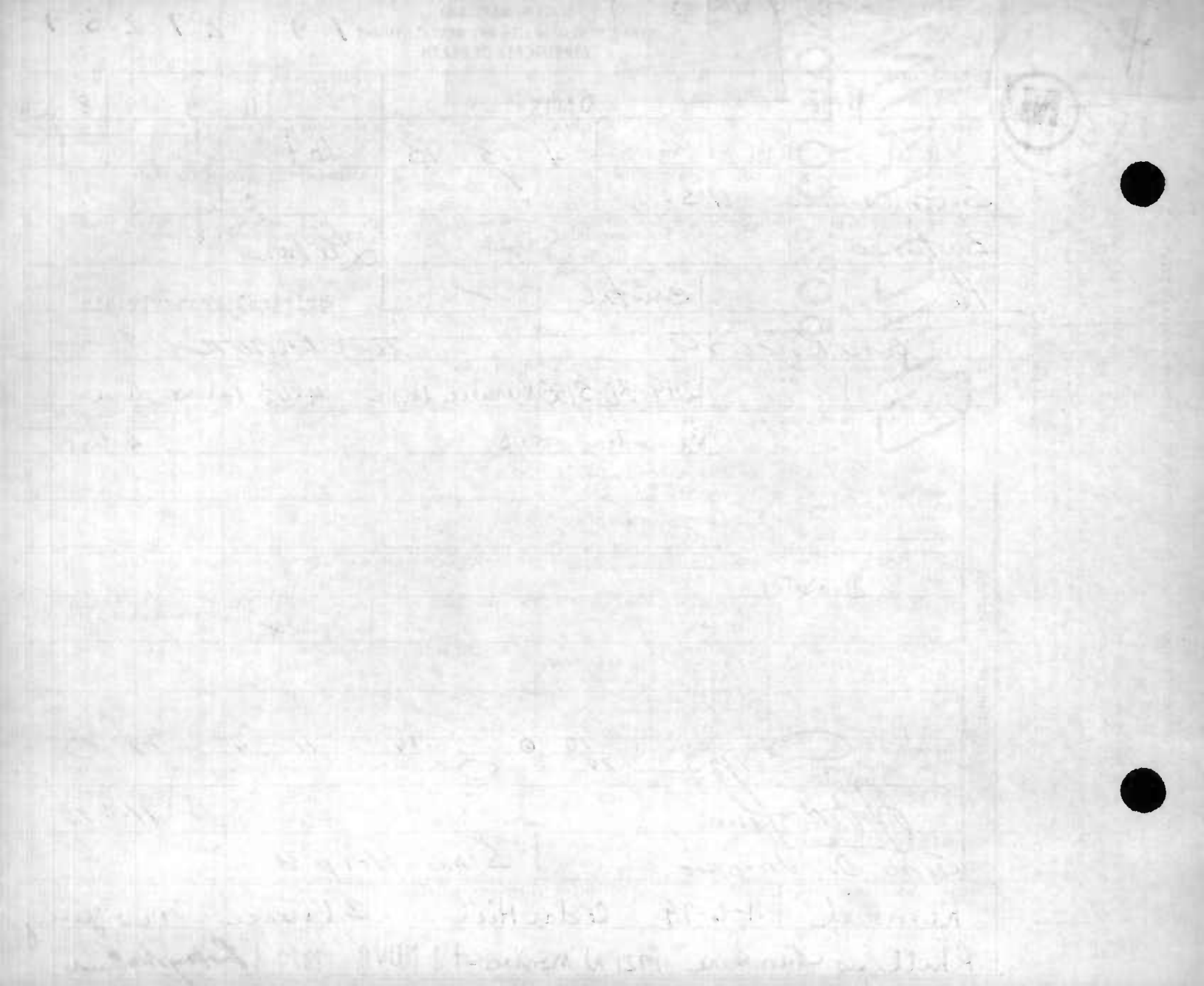
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Mingo DAVIS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 4 - 79</b>				2b. HOUR <b>8 a.m.</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 15 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>city</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SIWA I</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labar</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Pa.</b>		13b. COUNTY <b>Bristol</b>		13c. CITY OR TOWN <b>Bristol</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Bristol Pennsylvania</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>un Known</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>un Known</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>249-30-5955</b>		17. INFORMANT ADDRESS <b>Paralee Davis 4803 Palmer Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brainstem cut</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HAS CVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-30</b> , 19 <b>79</b> , to <b>11-4</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>10-30</b> , 19 <b>79</b> , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death, so state.)									
22b. SIGNATURE <b>Gino Di Vittorio</b>						DEGREE <b>Attending Physician</b>		22c. DATE SIGNED <b>11-4-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gino Di Vittorio</b>						22e. ADDRESS <b>Sinai Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>11-6-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore New Jersey</b>		
24. FUNERAL DIRECTOR NAME <b>Phillips Fun. Home</b>						ADDRESS <b>1721 N. Monmouth St.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 6 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert H. Brady</b>									



## CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RUTH M DAVIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-28-79</b>		2b. HOUR <b>11:35 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 17 43</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>36</b> YRS.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS Hosp.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3049 Brighton St</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Tim</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ARKWE WILSON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>212-40-0823</b>		17. INFORMANT ADDRESS <b>3049 Brighton St</b> <b>MRS. EARLENE Douglas</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Widespread Metastatic Carcinoma</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lobular Carcinoma of (R) Breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Months</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pancreatic Insufficiency due to Alcoholism</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <b>10-12, 19 79</b> to <b>11-28, 19 79</b> , that (1) <del>was</del> lost saw the deceased alive on <b>11-27, 19 79</b> , and that in my <del>own</del> opinion death occurred on the date and hour and from the causes stated above (1) <del>was</del> (did) <del>not</del> view the body after death.						
22b. SIGNATURE <b>William R. Law MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-28-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM R. LAW MD</b>		22e. ADDRESS <b>C/O BON SECOURS HOSPITAL 2000 W. BALTO. ST. BALTO. MD 21223</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-4-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN CEM.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MD.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>HERBERT E. NUTTER 3035 W. NORTH AV.</b>				
25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Brady</b>				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 236 g537 11/19/79 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 6 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thomas W. Davis, <del>xxxx</del>			2a. DATE OF DEATH MONTH DAY YEAR 11 6 1979		2b. HOUR 1:00 P.M.		
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 9 9 88		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	9b. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder		12b. KIND OF BUSINESS OR INDUSTRY Real Estate		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 103 W. 4th Ave Balt. MD.
14. FATHER'S NAME FIRST MIDDLE LAST Thomas W. Davis, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <del>XXXXXX</del> Lily R. Tilton, <del>xxxx</del>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-28-9285		17. INFORMANT ADDRESS Mrs. Ruth P. Davis 103 W. 4th Ave. Balto., Md. 21225			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMO THORAX</u> 492- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE EMPHYSEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-30</u> , 19 <u>79</u> , to <u>11-6</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov 11</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Myeung gin Lim		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 11/06/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Myeung gin Lim		22e. ADDRESS South Baltimore General Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/10/79	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY Baltimore Anne Arundel Md.
24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home of Brooklyn		25a. DATE REC'D. BY REGISTRAR 21225	25b. REGISTRAR'S SIGNATURE NOV 14 1979

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9 2 7 2 6 2  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SUSAN E. DEAN		2a. DATE OF DEATH MONTH DAY YEAR 11-4-79 2:29 P.M.	
3 SEX F	4 RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 7-1-09	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY. MD.
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife
13a. STATE Md.		13b. COUNTY --	13c. CITY OR TOWN Balto.
14. FATHER'S NAME FIRST MIDDLE LAST WM H. MURRAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST 301 McMechen St.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 034-18-9182	
17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5990 SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) UTI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): COPD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital) attended the deceased from 10/29/79 to 11-4-79, that I (we) last saw the deceased alive on 11-4-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did not view the body after death.)			
22b. SIGNATURE Patricia A. Snello M.D.		22c. DATE SIGNED 11-4-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A. SNELLO		22e. ADDRESS MERCY HOSP.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11/4/79	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board		25a. DATE REC'D. BY REGISTRAR NOV 09 1979	
25b. REGISTRAR'S SIGNATURE Loring K. Brandy			





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 6 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARY C. DEBES</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 9, 1979</b>		2b. HOUR <b>1:00</b> P.M.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 12 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Etzel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Comeau</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-54-3596</b>	
17. INFORMANT ADDRESS <b>Aloysius G. Debes Same</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHERO SCLEROTIC HEART DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>11/8/79</b> 19 to <b>11/9/79</b> 19, that (I) (we) lost saw the deceased alive on <b>11/9/79</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <b>Hales M. Patel M.D.</b>				DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/9/79</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HALES M. PATEL</b>				22d. ADDRESS <b>GOOD SAMARITAN HOSPITAL BALTIMORE, MD. 21239</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 12, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Fiftyhelndy</b>	



MAILED

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 6 4

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GRACE MARIE DeFRANCES</b>			2a. DATE OF DEATH MONTH <b>NOV</b> DAY <b>6</b> YEAR <b>1979</b>			2b. HOUR <b>9:00 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Can</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>5</b> YEAR <b>1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>246 S. ALBEMARLE ST</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>246 S. ALBEMARLE ST.</b>							
14. FATHER'S NAME FIRST <b>ANTHONY</b> MIDDLE LAST <b>SENGI</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE LAST <b>FEDDI</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-16-2672</b>		17. INFORMANT ADDRESS <b>ROCH DeFRANCES</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1579 Transition &amp; electrolyte imbalance</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic pancreatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>adenocarcinoma of pancreas</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b> <b>1 yr</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>none</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Salvatore DiMarconi</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/7/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SALVATORE DiMARCONI</b>				22e. ADDRESS <b>333 ST. PAUL PLACE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-8-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		23d. LOCATION CITY OR TOWN <b>BALTO</b> COUNTY <b>MD.</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Jerome Della Noce</b> ADDRESS <b>322 E. High St</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



11-5-11

11-5-11

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11-5-11

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>OWEN D. DEGROSS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 19 1979</b>		2b. HOUR <b>9:21 PM</b>
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 24 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	7. UNDER 1 YEAR MONTHS DAYS <b>0 0</b>
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	8b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1101 Rutland Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles De Gross</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Boston</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-07-9656</b>	17. INFORMANT ADDRESS <b>Bernice DeGross 1616 Meadow Wood Court</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1509</b> IMMEDIATE CAUSE (a) <b>Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory Distress</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Esophageal Carcinoma</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>10/22/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Esophageal Cancer</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/25</b> , 19 <b>79</b> , to <b>11/19</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William P. Banner, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/19/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.P. Banner, M.D.</b>		22e. ADDRESS <b>The Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/24/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>		ADDRESS <b>1101 East North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1979</b>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 6 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FREDERICK NAM I DEICHMILLER</b>		20. DATE OF DEATH MONTH DAY YEAR <b>11-8-79</b>		2b. HOUR <b>11:20 (P.M.)</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 10 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Inspector</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>PASADENA</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALWIN DEICHMILLER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Blanche Stafford</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>W.W. II 218-07-5980</b>		17. INFORMANT ADDRESS <b>Franklin, Tenn.</b> <b>Mrs. Mae L. Ferrell (Sister)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA of ESOPHAGUS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Barbara R. Cowley</b>				22c. DATE SIGNED <b>11/8/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARBARA R. COWLEY</b>				22e. ADDRESS <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>13 NOV '79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem.Pk.</b>	
24. FUNERAL DIRECTOR NAME <b>J. Easter</b>		ADDRESS <b>SINGLETON FUNERAL HOME, GLENBURNIE, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
23d. LOCATION CITY OR TOWN <b>Glen Burnie A.A.</b>		COUNTY <b>Md.</b>		STATE	

MEDICAL CERTIFICATION

DEICHMILLER

Erödörick num

2. 10. 1919

Witten

Inspector

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219-07-5580

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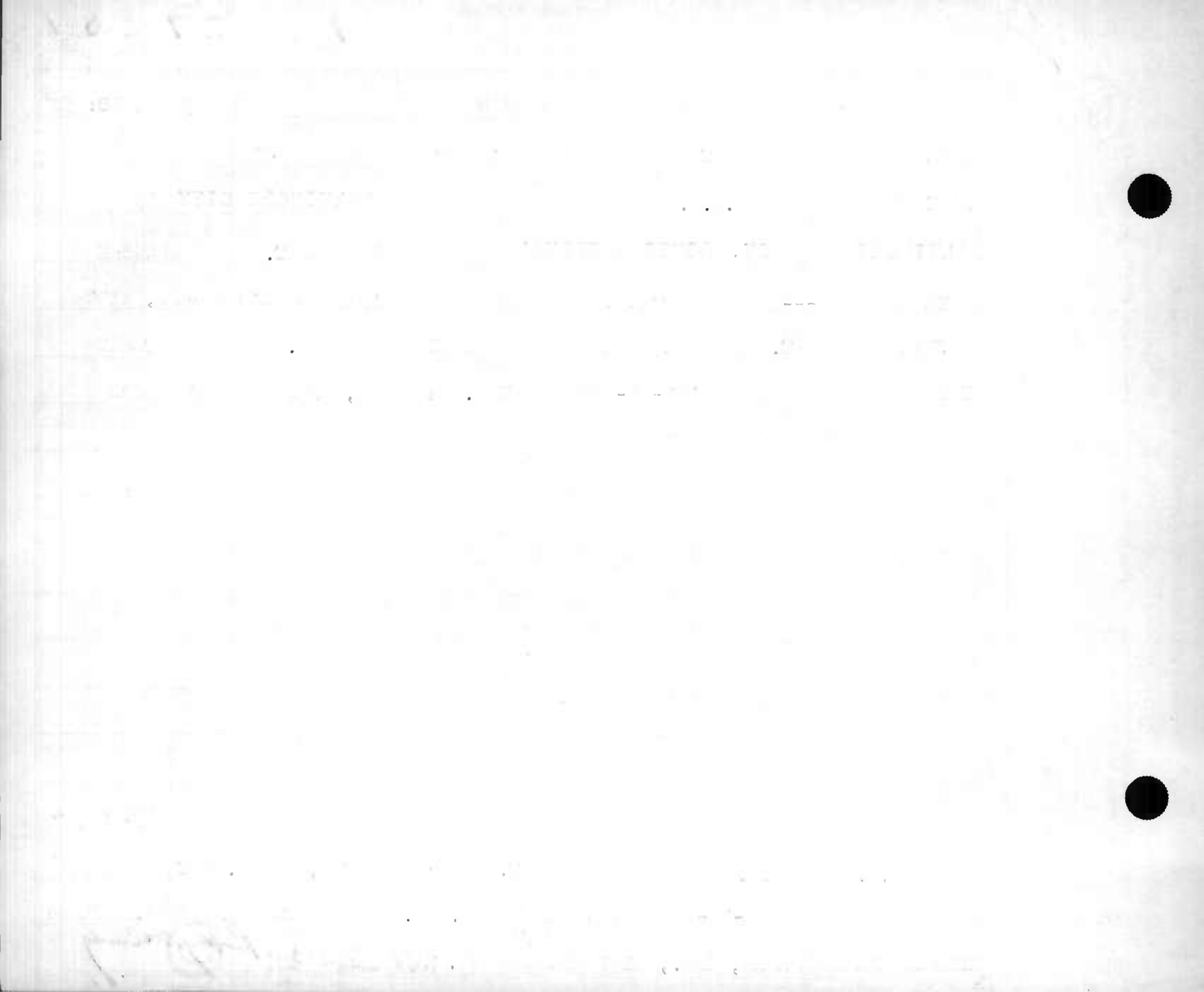


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 7 2 6 7
FOR 1 - STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES A DELAUDER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11 23 79</b>			2b. HOUR <b>10: 50 P</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 02 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67 YRS</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>00 00</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BEER DIST.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BREWERY</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>---</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3545 BENZINGER ROAD, 21229</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES T. DeLAUDER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY E. GREEN</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>MARY E. DeLAUDER, 3545 BENZINGER ROAD</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest -</b> <b>4414</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hyperkalemia -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute renal failure - &amp; severe vasculitis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Ischemic colitis.</b>										
19a. DATE OF OPERATION <b>11/19/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abdominal Aortic aneurysm</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>11/12</b> 19 <b>79</b> , to <b>11/25</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/23</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>L. B. Shah</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>11/23/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. B. SHAH M.D.</b>				22e. ADDRESS <b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-27-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELKRIDGE HOWARD MARYLAND</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>21229</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony Kelly</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9		2 7 2 6 8		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>mary E Dempsey</b>				2a. DATE OF DEATH MONTH <b>11</b> DAY <b>4</b> YEAR <b>79</b>		2b. HOUR <b>11/10 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>APRIL</b> DAY <b>4</b> YEAR <b>1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>baltimore city</b> MD.			
10. CITY OR TOWN OF DEATH <b>baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE, GIVE STREET ADDRESS) <b>union memorial hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FACTORY WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HAT</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>624 TUNBRIDGE RD.</b>			
14. FATHER'S NAME FIRST <b>MARTIN</b> MIDDLE <b>EPPL</b> LAST <b>EPPL</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>JANE</b> LAST <b>EPPL</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-50-5222</b>		17. INFORMANT ADDRESS <b>MRS. CLAY THOMPSON 5812 HALWYN AVE.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cachexia &amp; dehydration -</b> <b>2765</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>None</b>									
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) _____					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/4</b> 19 <b>79</b> , to <b>11/4</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/4</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gregory Faith</b>				DEGREE _____		22c. DATE SIGNED <b>11/4/79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GREGORY FAITH</b>	
22e. ADDRESS <b>h union memorial hospital</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>NOV. 7, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEM.</b>		23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY _____ STATE <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME</b> ADDRESS <b>6500 York rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

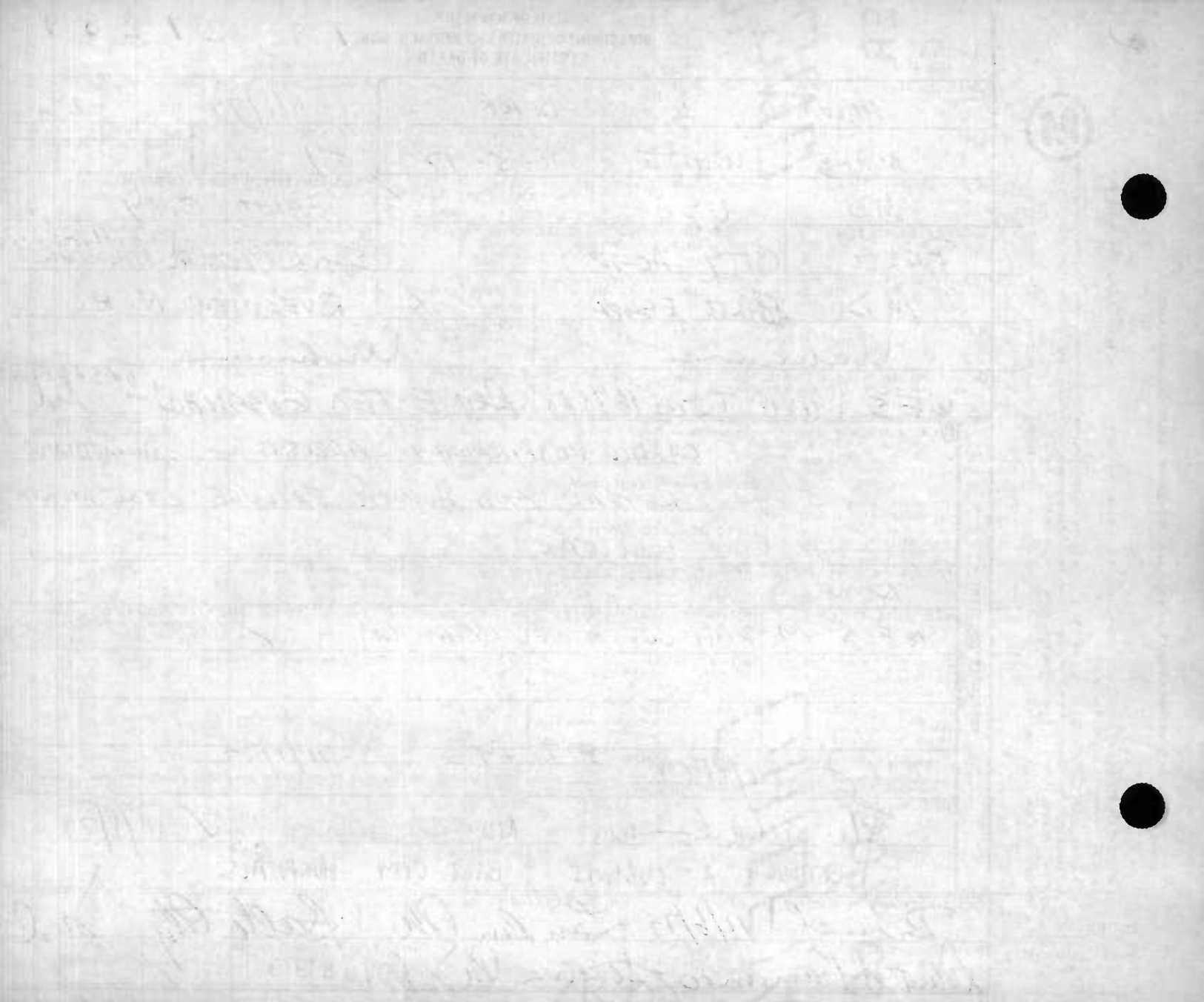
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VRA 15(4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 2 7 2 6 9	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD W. DERR					2a. DATE OF DEATH MONTH DAY YEAR 11/1/79				2b. HOUR 2:05 A.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10-5-92		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.					
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITY Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POOL CLEANER		12b. KIND OF BUSINESS OR INDUSTRY PLASTER			
13a. STATE MD					13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. WWW 215 167868		17. INFORMANT ADDRESS REV. E. TED GASSMAN - PASADENA MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 586- CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RENAL AND HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) UNCLEAR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE ONE MONTH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NONE											
19a. DATE OF OPERATION 8-5-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RULE OUT BOWEL OBSTRUCTION				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8-5-79, 19, to 11/1/79, 19, that (I) (we) last saw the deceased alive on 11/1/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.											
22b. SIGNATURE Stu. Culak MD				DEGREE MD				22c. DATE SIGNED 11/1/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) BETHANY A. EVANKS	
22e. ADDRESS BALTO. CITY HOSPITALS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/6/79		23c. NAME OF CEMETERY OR CREMATORY Landon Ph		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD					
24. FUNERAL DIRECTOR Leland S. Baranow - Severna Ph				25a. DATE REC'D. BY REGISTRAR NOV 06 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 7 2 7 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLIE Herman DERRICK, Jr.				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 19, 1979			
3. SEX male				4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 26, 1954	
6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS.				7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12. CITY OR TOWN OF DEATH Baltimore				13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus	
15. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				16. STREET ADDRESS 1012 Circle Drive (21227)			
17. FATHER'S NAME FIRST MIDDLE LAST Charlie H. Derrick, Sr.				18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia Jane Bourne			
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES no				20. SOCIAL SECURITY NO. 216 68 5835		21. INFORMANT ADDRESS Jane Derrick 1012 Circle Drive Arbutus, Maryland 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CENTRAL NERVOUS SYSTEM BLEEDING 2051 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC MYELOCYTIC LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from Nov 18 19 79, to Nov 19 19 79, that (I) (we) last saw the deceased alive on Nov 19 (5:20AM) 19 79, and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John L Sullivan MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 19 Nov 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 11/21/79		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City, Howard, Maryland	
24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043				25. DATE REC'D. BY REGISTRAR NOV 23 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>ELIZABETH B. DESHIELDS</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>NOVEMBER 17, 1979</u>			2b. HOUR <u>10:28 P.M.</u>	
3. SEX <u>Female</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>3 22 1910</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD.			
10. CITY OR TOWN OF DEATH <u>BALTIMORE CITY</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Provident Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS		
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. STREET ADDRESS <u>4118 Park Heights</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Clarence Burrell</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Lottie Blackwell</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <u>217-22-6952A</u>		17. INFORMANT ADDRESS <u>Louise Clemens 2874 Woodbrook Avenue</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>IRREVERSIBLE SHOCK</u> <u>5672</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DIFUSE PERITONITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>PHILLOSTOMA ABDOMINAL VISCUS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>6 hours</u> <u>10 hours</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Not known</u>									
19a. DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 17, 1979</u> to <u>NOVEMBER 17, 1979</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 17, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Nathaniel G. Hagler, III</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>11-17-79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NATHANIEL G. HAGLER, III</u>				22e. ADDRESS <u>PROVIDENT HOSP. 2400 LIBERTY HEIGHTS AVE BALTO, MD 21201</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11/21/1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Wm. C. March F/H 1101 East North Avenue</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 20 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Frispy Melroy</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 2 7 2 7 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>STEPHEN R. DE SHIELDS</b>					2a. DATE OF DEATH MONTH <b>11</b> DAY <b>28</b> YEAR <b>79</b>			2b. HOUR <b>1:50P</b> M	
3 SEX <b>MALE</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH MONTH <b>8</b> DAY <b>15</b> YEAR <b>1914</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER BALTO.MD.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>MARYLAND</b>		13b COUNTY		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>1919 W. LANVALE STREET 21217</b>	
14 FATHER'S NAME FIRST <b>Lawrence</b> MIDDLE <b>DeShields</b> LAST <b>DeShields</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Muir</b> LAST <b>Muir</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b SOCIAL SECURITY NO. <b>WW II</b>		17 INFORMANT ADDRESS <b>Elizabeth Reed 2623 East Biddle Street</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MASSIVE B SIDED CVA</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (1) (this hospital) attended the deceased from <b>NOV. 25, 19 79</b> to <b>NOV. 28, 19 79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>NOV. 28, 19 79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>M. So MD</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c DATE SIGNED <b>11/28/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. So MD</b>					22e ADDRESS <b>3900 LOCH RAVEN BLVD, BALTO.MD. 21218</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>12/3/1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24 FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Avenue</b>					25a DATE REC'D. BY REGISTRAR <b>NOV 29 1979</b>		25b SIGNATURE <b>[Signature]</b>		

NOV 22 1954  
U.S. AIR FORCE  
WASHINGTON, D.C.  
AIR MAIL  
NOV 22 1954  
U.S. AIR FORCE  
WASHINGTON, D.C.

NOV 22 1954  
U.S. AIR FORCE  
WASHINGTON, D.C.

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U.S. AIR FORCE  
WASHINGTON, D.C.  
NOV 22 1954  
U.S. AIR FORCE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
7 9 2 7 2 7 3 CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY DETERER					2a. DATE OF DEATH MONTH DAY YEAR HOUR November 7 79 3p M					
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 5 1906		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) W.Va. Paper		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Deterer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Kouts					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-01-0711		17. INFORMANT ADDRESS A Mrs. Anna Deterer, same						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock 4413 DUE TO, OR AS A CONSEQUENCE OF (b) unknown septic source Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) S/P Repair of ruptured aortic aneurysm									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours 50 days 25 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from 10/29 19 79, to 11/7 19 79, that (1) (we) lost saw the deceased alive on 11/7 19 79 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE K. L. Llemoe				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 11/7		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. L. Llemoe				22e. ADDRESS 1557 E. Monument						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/10/79		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Zannino Funeral Home, 263 S. Conkling St				25a. DATE REC'D. BY REGISTRAR NOV 9 1979		25b. REGISTRAR'S SIGNATURE R. J. McHenry				

2101 11/11/11

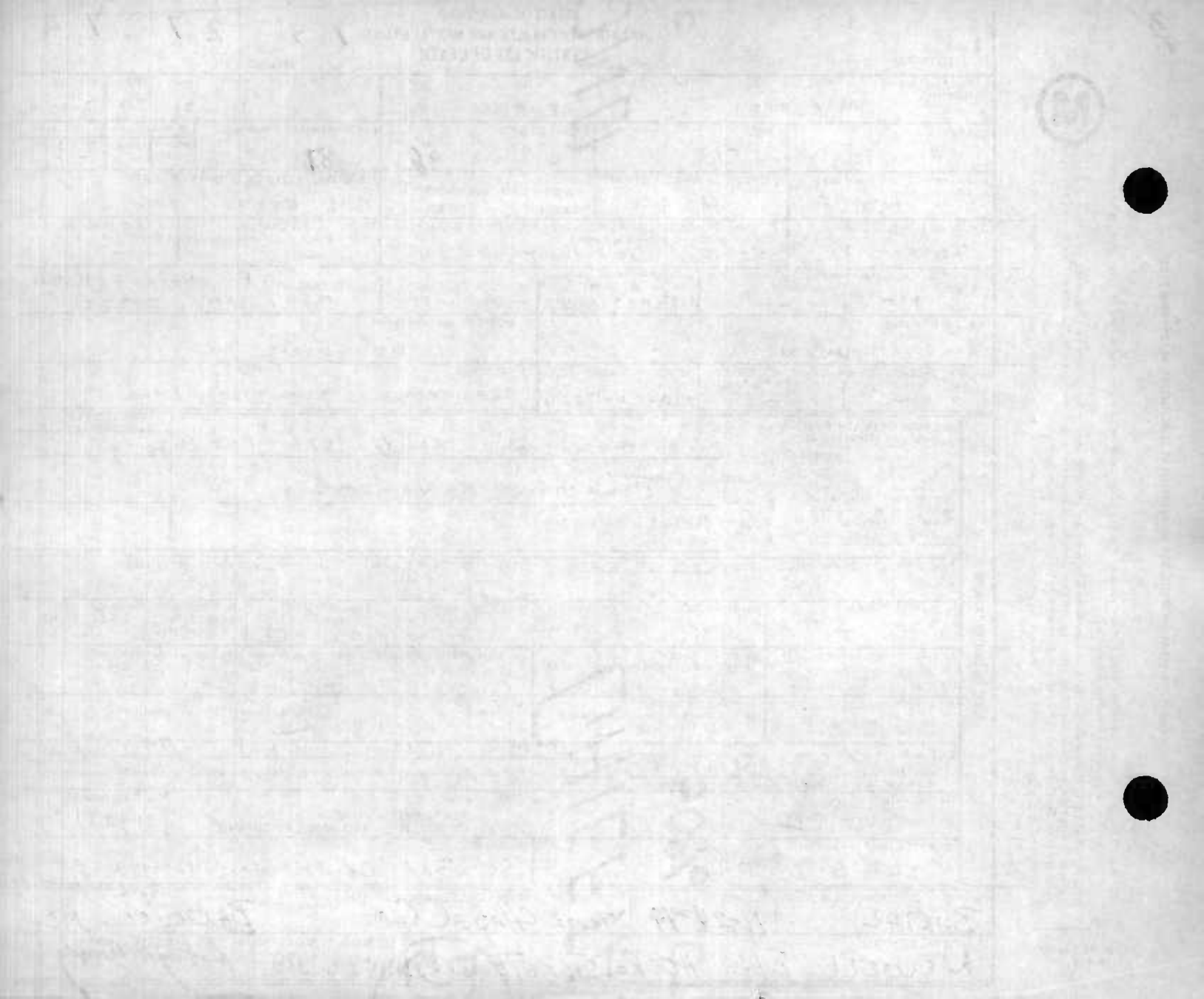


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 7 2 7 4	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET DEVERS				2a. DATE OF DEATH MONTH DAY YEAR 11 21 '79 2b. HOUR 3:15 AM	
3. SEX Female		4. RACE FIC.		5. DATE OF BIRTH MONTH DAY YEAR 07 08 98	
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		8. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS - -	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		9b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BAL. CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Bal. Gen. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -	
13a. STATE MD.		13b. COUNTY -		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16. SOCIAL SECURITY NO. 219-20-7324	
17. INFORMANT Rosemary		18. ADDRESS 206. Mason Lane. 4		19. DATE OF OPERATION -	
20. DATE OF OPERATION -		21. CONDITION FOR WHICH OPERATION WAS PERFORMED -		22. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23. DATE OF OPERATION -		24. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		25. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -	
26. DATE OF OPERATION -		27. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		28. LOCATION STREET CITY OR TOWN COUNTY STATE - - - - -	
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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

7 9 2 7 2 7 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE Elizabeth DIEHL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 30, 1979</b>			2b. HOUR <b>11:13</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 18, 1979</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>12</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN <b>12</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Port Deposit</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Larry E. Diehl</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Janet L. David</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17 INFORMANT ADDRESS <b>Larry E. Diehl, 429 Craigtown Rd., Port Deposit</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b> <b>7470</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGENITAL HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>RENAL FAILURE, PULMONARY EDEMA, STATUS EPILEPTICUS</b>										
19a. DATE OF OPERATION <b>11-28-79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PATENT DUCTUS ARTERIOSUS</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>11-25</b> , 19 <b>79</b> , to <b>11-30</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11-30</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Nancy Hutton MD</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11-30-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NANCY HUTTON</b>						22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 3, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Colora, Cecil, Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Lee A. Patterson &amp; Son, Perryville, Maryland</b>						25a. DATE REC'D BY REGISTRAR <b>DEC 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey McBrady</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the funeral home. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 2593. 2594. 2595. 2596. 2597. 2598. 2599. 2600. 2601. 2602. 2603. 2604. 2605. 2606. 2607. 2608. 2609. 2610. 2611. 2612. 2613. 2614. 2615. 2616. 2617. 2618. 2619. 2620. 2621. 2622. 2623. 2624. 2625. 2626. 2627. 2628. 2629. 2630. 2631. 2632. 2633. 26

Dec. 3, 1977

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Page 1** may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

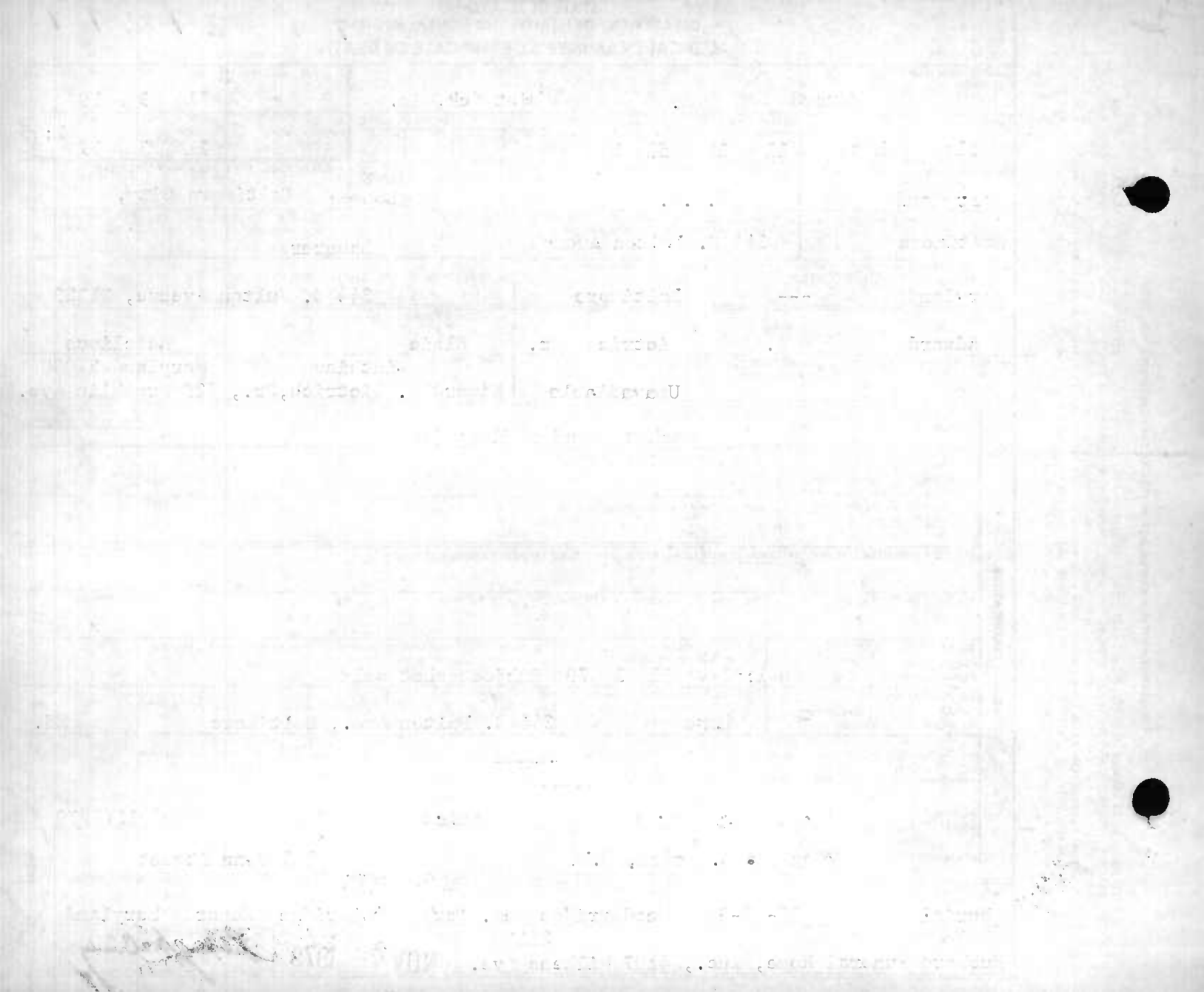
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 9 2 7 2 7 6  |  |   |  |
|---|--|---|--|--|--|---|--|
| FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>ANNA T. DIETRICH   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>November 9, 1979  |  |   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Aug. 31, 1891  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Garment   |  |
| 13a STATE<br>Maryland   |  |   |  | 13b COUNTY<br>21202  |  | 13c CITY OR TOWN<br>Baltimore   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>John Dietrich   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Catherine Toland   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b SOCIAL SECURITY NO.<br>178-05-6534   |  | 17 INFORMANT ADDRESS<br>Albert Mrowka 1001 St. Paul St.   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension - years</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from 19 76, to 19 79, that (I) (we) lost saw the deceased alive on 11/9/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b SIGNATURE<br>Louis P. Hamburger Jr.   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c DATE SIGNED<br>11/9/79  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Louis P. Hamburger Jr.  |  |   |  | 22e ADDRESS<br>1001 St Paul St Baltimore, Md 21202   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b DATE<br>11/13/79  |  | 23c NAME OF CEMETERY OR CREMATORY<br>St. Edwards Cem.  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Shamokin, Pennsylvania  |  |
| 24 FUNERAL DIRECTOR NAME<br>William E. Johnson  |  |   |  | ADDRESS<br>8521 Loch Raven Blvd  |  | 25a DATE REC'D. BY REGISTRAR<br>NOV 15 1979   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |                         |  |   |  |   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  |   |  |   |  |  |  | REG. NO.                          |  |                                      |  |
|--|--|-------------------------|--|---|--|---|--|---|--|---|--|--|--|---|--|---|--|--|--|-----------------------------------|--|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Edward A. Dietrich, Jr.</b>   |  |                         |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>11 3 19 79</b>  |  |  |  |   |  |   |  |  |  | 2b. HOUR<br>M<br><b>2:05 P.M.</b> |  |                                      |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 13 51</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>27 YRS.</b>  |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 3 19 79</b>    |  |   |  |   |  |  |  |                                   |  | 2d. HOUR<br>P.M.<br><b>2:05 P.M.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b> |  |   |  |   |  |  |  |                                   |  |                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>344 S. Fulton Avenue</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>                         |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                         |  |  |  |                                   |  |                                      |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |                         |  |   |  |   |  |   |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>344 S. Fulton Avenue, 21223</b> |  |  |  |                                   |  |                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward A. Dietrich Sr.</b>  |  |                         |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Redelious</b>                                 |  |  |  |   |  |   |  |  |  |                                   |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>Unavailable</b>  |  | 17. INFORMANT ADDRESS<br><b>Linthicum Maryland 21090</b><br><b>Edward A. Dietrich, Sr., 625 Franklin Ave.</b> |  |   |  |   |  |  |  |   |  |   |  |  |  |                                   |  |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head (rifle)</b><br>9552<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                         |  |   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |                                   |  |                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |   |  |   |  |   |  |  |  |   |  |   |  |  |  |                                   |  |                                      |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |   |  |  |  |                                   |  |                                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR <del>XX</del> MONTH DAY YEAR<br><b>1:58 P.M. 11 3 1979</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot self</b>   |  |   |  |  |  |   |  |   |  |  |  |                                   |  |                                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>344 S. Fulton Ave., Baltimore Md.</b>   |  |   |  |  |  |   |  |   |  |  |  |                                   |  |                                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |   |  |   |  |  |  |   |  |   |  |  |  |                                   |  |                                      |  |
| ACTUAL SIGNATURE<br><i>Virginia L. Dolan</i>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br><b>11/4/79</b>                                      |  |   |  |   |  |  |  |                                   |  |                                      |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |  |                         |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |   |  |   |  |  |  |   |  |   |  |  |  |                                   |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>11-07-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard Maryland</b>                           |  |  |  |   |  |   |  |  |  |                                   |  |                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc., 4107 Wilkens Ave.</b>   |  |                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Harry Belmont</i>  |  |   |  |   |  |  |  |   |  |   |  |  |  |                                   |  |                                      |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR   |                  |  |  |   |  |   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |                                |  |   |  |  |  | REG. NO. 27278 |  |
|--|------------------|--|--|---|--|---|--|--|--|--|--|---|--|--------------------------------|--|---|--|--|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                  | FIRST<br>Edward  |  | MIDDLE<br>A.  |  | LAST<br>Dietrich, III   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11 3 1979 |  |  |  | 2b. HOUR<br>M<br>2:05 PM  |  |                                |  |   |  |  |  |                |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 30 78   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>1 YRS.                                  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.<br>HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 3 1979                            |  |   |  | 2d. HOUR<br>PM                 |  |   |  |  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                        |  |   |  |                                |  |   |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>344 S. Fulton Avenue |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |                                |  |   |  |  |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |  |  |   |  | 13a. STATE<br>Maryland  |  |  |  |  |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>344 S. Fulton Avenue, 21223 |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward A. Dietrich Jr.   |                  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Joan A. Propst   |  |  |  |  |  |   |  |                                |  |   |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>N/A   |                  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-90-1465          |  | 17. INFORMANT<br>ADDRESS<br>Joan Meeks, 312 S. Fulton Avenue, 21223   |  |  |  |  |  |   |  |                                |  |   |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Stab Wounds<br>966-<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |                  |  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                |  |   |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |  |  |   |  |   |  |  |  |  |  |   |  |                                |  |   |  |  |  |                |  |
| 19a. DATE OF OPERATION   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                               |  |   |  |  |  |  |  | 20. AUTOPSY<br>Body Only<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |   |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |  |  | 21b. TIME OF INJURY<br>HOUR <del>XX</del> MONTH DAY YEAR<br>1:58 P.M. 11 3 1979 |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Subject stabbed     |  |  |  |   |  |                                |  |   |  |  |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home             |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>344 S. Fulton Ave., Baltimore Md.               |  |  |  |   |  |                                |  |   |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |   |  |   |  |  |  |  |  |   |  |                                |  |   |  |  |  |                |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |                  |  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER<br>111 Penn Street  |  |  |  | DATE SIGNED<br>11/4/79  |  |                                |  |   |  |  |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |                  |  |  | ADDRESS   |  |   |  |  |  |  |  |   |  |                                |  |   |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  |  |  | 23b. DATE<br>11-07-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland              |  |   |  |                                |  |   |  |  |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc., 4107 Wilkens Ave.  |                  |  |  | ADDRESS<br>21229  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1979   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |                                |  |   |  |  |  |                |  |







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR 15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

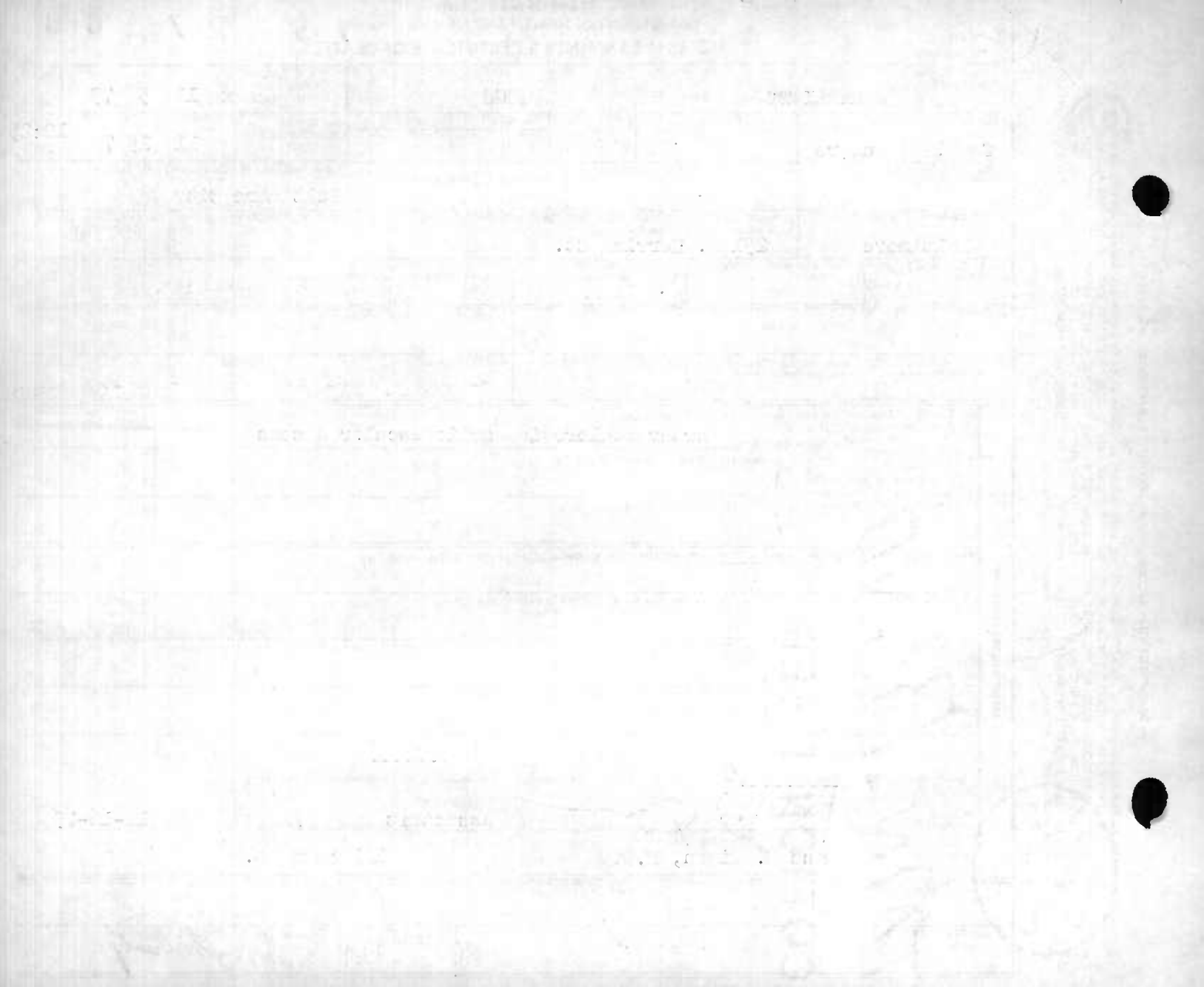
|   |  |   |   |  |
|---|--|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 20. DATE KNOWN<br>OF DEATH ESTI-<br>MATED <input checked="" type="checkbox"/> MONTH DAY YEAR  |   | 21. HOUR   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE  | LAST   |
| Shanee  |  | L.  | Dietrich  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |
| Female  | White  | 02 01 77  | 2 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Maryland  | U.S.A.   |   | Baltimore City, MD.   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |
| Baltimore   | 344 S. Fulton Avenue   | N/A   |   |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS  |
| Maryland  | ---  | Baltimore   |   | 344 S. Fulton Avenue, 21223  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |   |  |
| Edward A. Dietrich Jr.  | Joan A. Propst   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |   |  |
| N/A   | 212-90-1034  | Joan A. Meeks, 312 S. Fulton Avenue   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Stab Wounds</u><br><u>966 -</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |   |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   | 20. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY<br>HOUR <u>5:58</u> MONTH DAY YEAR<br>P.M. <u>11</u> <u>3</u> <u>1979</u>              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject stabbed  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>home                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>344 S. Fulton Ave., Baltimore Md.  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |   |  |
| ACTUAL<br>SIGNATURE <u>Virginia L. Dolan</u>  | TITLE (SPECIFY)<br>Assistant   |   |   | DATE<br>SIGNED <u>11/4/79</u>  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  | ADDRESS  |   |   |  |
| Virginia L. Dolan, M.D.   | 111 Penn Street  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| Burial  | 11-07-79   | Loudon Park   | Baltimore City Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |  |
| Hubbard Funeral Home, Inc., 4107 Wilkens Ave.   | NOV 7 1979   |   | <u>Robert M. Henry</u>  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 1 HOUR AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

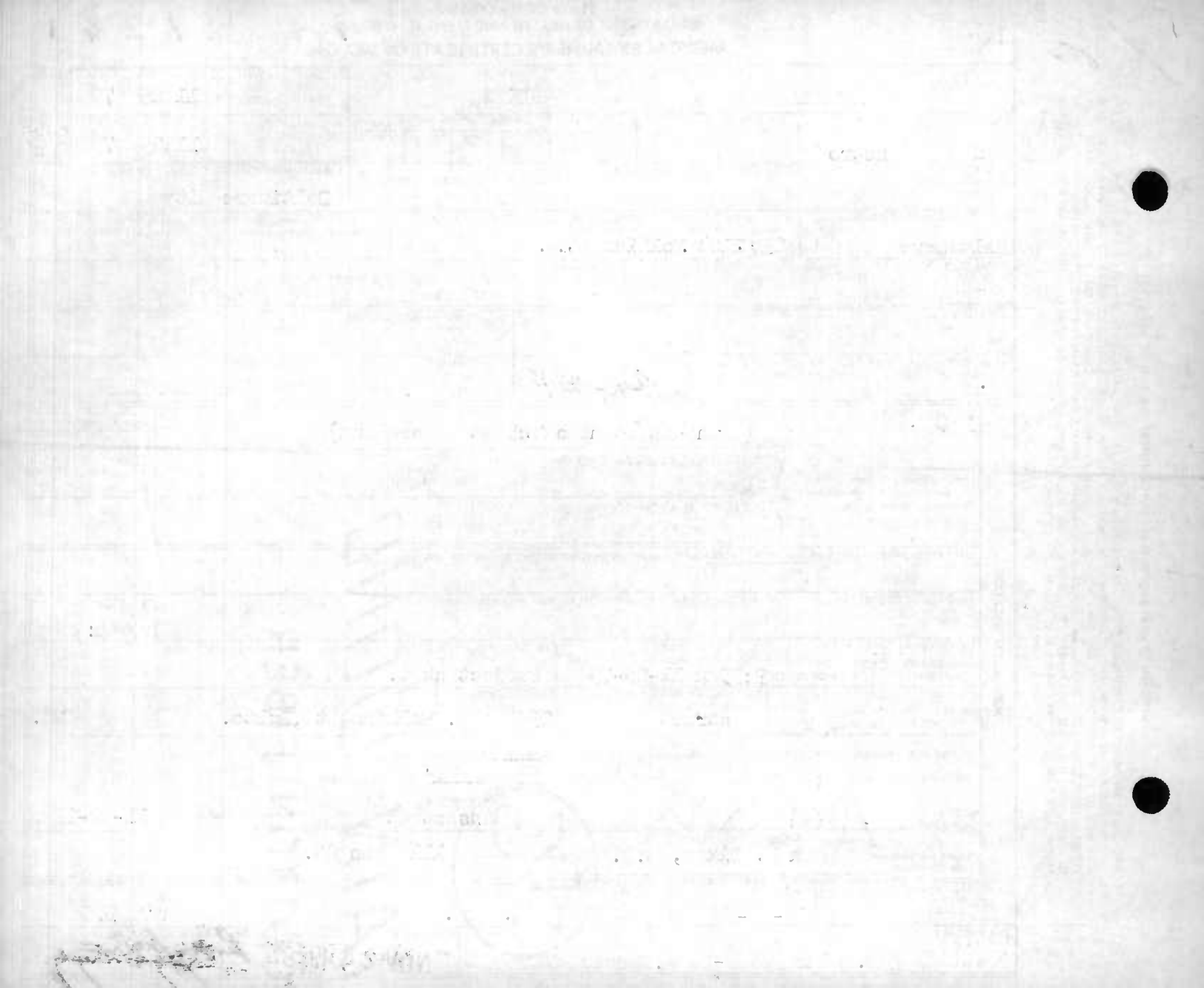
## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |   |  |   |  |   |  |  |                                   | 7 9 2 7 2 8 0   |  |
|--|---------|---|--|---|--|---|--|--|-----------------------------------|---|--|
| 1. FOR STATE REGISTRAR   |         |   |  |   |  |   |  |  |                                   | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |                                   | 2b. HOUR  |  |
| HARRIETT   |         | H.  |  | DIGGS   |  |   |  | KNOWN <input type="checkbox"/> MONTH DAY YEAR<br>ESTIMATED <input checked="" type="checkbox"/> 11 5 1979 |                                   | 12:25 p.m.  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.   |                                   | 2c. DATE PRONOUNCED DEAD  |  |
| female   | negro   | 8 7 93  |  | 86 YRS.   |  |   |  |  |                                   | 11 15 79  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |                                   |   |  |
| Md.  |         | USA   |  | Baltimore City MD.  |  |   |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| Baltimore  |         | 251 S. Herring Ct.  |  |   |  |   |  |  |                                   |   |  |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |                                   |   |  |
| Md.  |         |   |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 251 Herring Ct.  |                                   |   |  |
| 14. FATHER'S NAME  |         |   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |                                   |   |  |
| FIRST MIDDLE LAST  |         |   |  | FIRST MIDDLE LAST   |  |   |  |  |                                   |   |  |
| Unkn   |         |   |  | Unkn  |  |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |   |  | ADDRESS  |                                   |   |  |
| No   |         |   |  | James G. Diggs  |  |   |  | 1829 Rutland Avenue  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |   |  |   |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |  |   |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |                                   | 20. AUTOPSY?  |  |
|  |         |   |  |   |  |   |  |  |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |                                   |   |  |
|  |         | HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  |   |  |  |                                   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION   |  |   |  |  |                                   |   |  |
|  |         |   |  | STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |                                   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |   |  |   |  |   |  |  |                                   |   |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |  |   |  | DATE SIGNED   |  |  |                                   |   |  |
| Ann M. Dixon, M.D.   |         | Assistant   |  |   |  | 11-16-79  |  |  |                                   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |  |   |  |   |  |  |                                   |   |  |
| Ann M. Dixon, M.D.   |         | 111 Penn St.  |  |   |  |   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |  |                                   |   |  |
| Burial   |         | 11/21/79  |  | Mt. Calvary Cem.  |  | Anne Arundel Co. d.   |  |  |                                   |   |  |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR   |  |   |  | REGISTRAR'S SIGNATURE   |  |  |                                   |   |  |
| NAME C March F/H   |         | 1101 W. North Ave   |  |   |  | NOV 21 1979   |  |  |                                   |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |   |   |   |   | REG. NO. 9 27281  |  |
|--|--|------------------|--|--|--|---|---|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |                  |  |  |  |   |   |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ROBERT DIXON  |  |                  |  |  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>11 25 1979   |   |   | 2b. HOUR<br>M<br>9:45 a.m.  |   |  |
| SEX<br>male  |  | 4. RACE<br>negro |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 15 33                         |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>46 YRS.   |   | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN   |   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 25 1979                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA  |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.        |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN CITY OR TOWN, GIVE STREET ADDRESS)<br>2300 blk. Hollins St. |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DISABLED |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MARYLAND   |  |                  |  |  |  | 13b. COUNTY<br>BALTIMORE  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13d. STREET ADDRESS<br>2104 HOLLINS STREET  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE DIXON   |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MINNIE BROWN   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>229-42-4248 |  | 17. INFORMANT ADDRESS<br>VIOLA DIXON 2104 HOLLINS STREET  |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 9650 Gunshot wound of chest (handgun)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |  |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>9:35xx 11-25-79     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject shot.  |   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2300 blk. Hollins St., Balto. MD.  |   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br>[Signature]  |  |                  |  | TITLE (SPECIFY)<br>Assistant   |  |   |   | DATE SIGNED<br>11-26-79   |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |                  |  | ADDRESS<br>111 Penn St.  |  |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>REMOVAL  |  |                  |  | 23b. DATE<br>11-27-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Mem. Cem.   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Portsmouth Virginia |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>PHILLIPS FUN. HOME 1721-27 N. Monroe Street  |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |   |  |  |  |
|--|--|--|--|--|--|---|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |   |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |   |  |  |  |
| REG. NO. 7 9 2 7 2 8 2   |  |  |  |  |  |   |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Naomi DeHoff Donker   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-24-79   |   |   | 2b. HOUR MIN<br>1:00 PM                                      |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 20 17  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS                            |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.           |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Keswick Nursing Home |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland  |  |  |  |  | 13b. COUNTY Baltimore  |   | 13c. CITY OR TOWN Towson  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>C. Earl DeHoff   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>May Webster  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>212-18-5490A   |  | 17 INFORMANT<br>Charles W. Donker  |  |   | ADDRESS<br>Same   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Sept. pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>0389</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 days       |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>ASCVD + Steele-Reichman Syndrome</u>  |  |  |  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                  |  |  |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE <u>Harold P. Briere MD</u> DEGREE   |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>11-24-79                                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>11/26/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <u>Mitchell-Windfeldt Phone 6500 Yakel</u> ADDRESS   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1979   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Brady</u>  |  |  |  |

2000

Figure 1



FOR  
1 - STATE  
REGISTRAR

|   |  |  |   |  |   |  |   |  |  |
|---|--|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Beatrice Nonnelly</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 3 79</b> |  |   | 2b. HOUR <b>10:10 P.M.</b>   |   |  |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>BLACK</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>APR. 27 1893</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City MD.</b>  |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3800 Callaway Ave.</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |   |  |  |
| 13a. STATE <b>MD.</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN <b>Balto.</b>  |   | 13e. STREET ADDRESS <b>1400 Madison St.</b>  |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>? ? ?</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>? ? ?</b>  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>213-26-2711</b>  |   | 17. INFORMANT ADDRESS <b>LOLA BROWN 622 Poplar Grove St.</b>   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |  |   |  |   |  |  |
| IMMEDIATE CAUSE (a) <b>4149 Cardio - Pulmonary Arrest</b>   |  |  |   |  |   |  | <b>5 min.</b>   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |   |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |   |  |   |  |  |
| (b) <b>Coronary Artery Disease</b>  |  |  |   |  |   |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |   |  |   |  |  |
| (c)   |  |  |   |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |  |   |  |  |
| <b>Adult Onset Diabetes Mellitus</b>  |  |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION <b>9/8/79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Osteomyelitis - Right toes</b>   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>September 7</b> , 19 <b>79</b> , to <b>October 29</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>October 29</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE <b>James W. Rathorn MD</b>   |  |  |   | DEGREE <b>MD</b>   |   | 22c. DATE SIGNED <b>11/5/79</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES W. RATHORN</b>   |  |  |   | 22e. ADDRESS <b>Johns Hopkins Hospital</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>OCT. 8 1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Ex.</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Kenn Arundel Co. MD</b>                                     |   |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Locks Funeral Home</b>   |  |  |   | ADDRESS <b>1504 N. Central Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Patricia M. Brady</b>  |  |

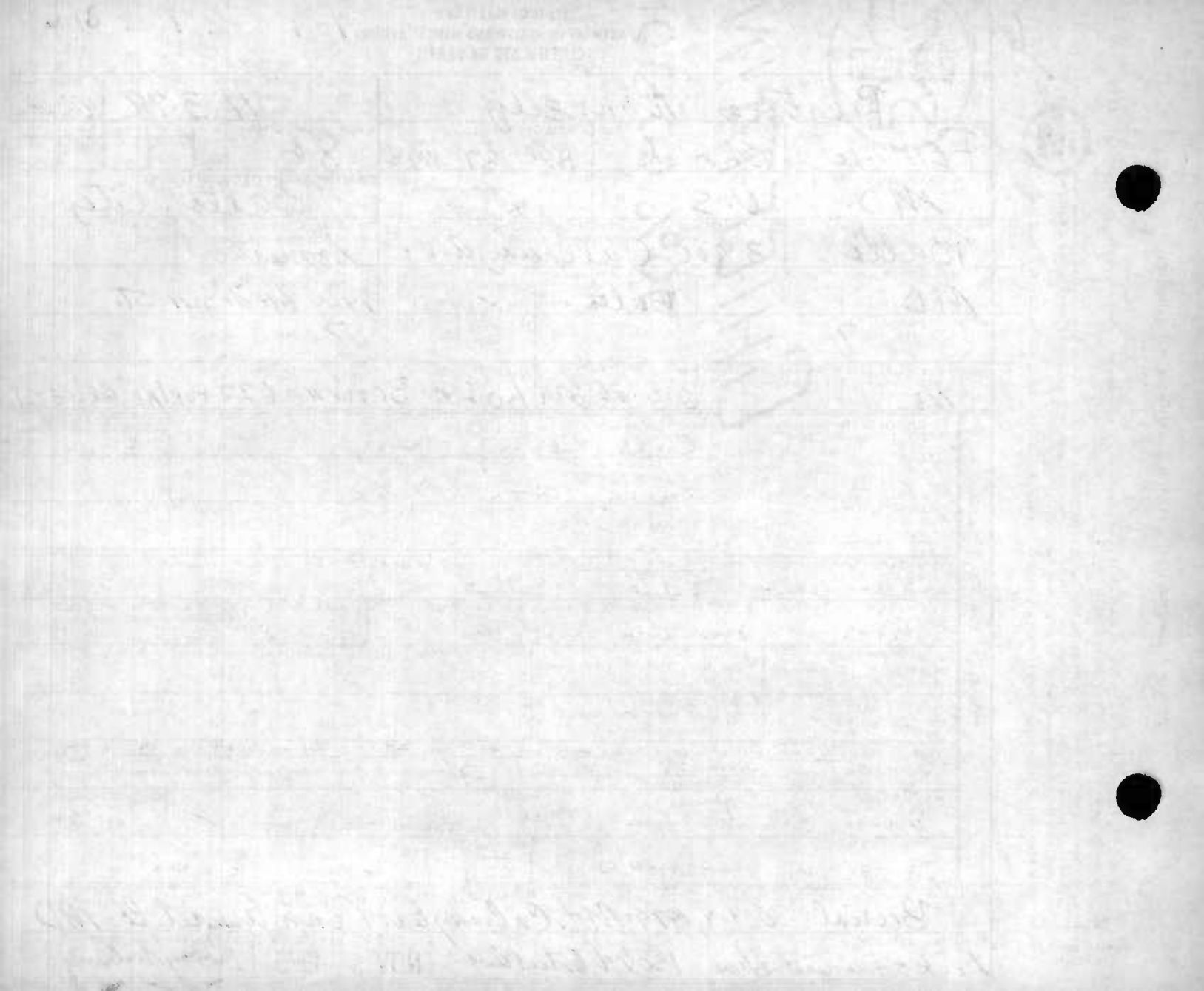
MEDICAL CERTIFICATION

2  
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |                            |  |
|--|--|---|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LAURA I DORSEY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 2 79</b> |  | 2b. HOUR<br><b>7:08 PM</b> |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>B</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 22 15</b>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Simpsonville Md.</b>   |   | 8. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |                            |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.  |  | 10. CITY OR TOWN OF DEATH<br><b>BALT CITY</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MD. HOSPITAL</b> |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                  |                            |  |
| 13b. COUNTY<br><b>BALT</b>   |  | 13c. CITY OR TOWN<br><b>ELLIOT CITY</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                            |  |
| 13e. STREET ADDRESS<br><b>3560 Apt D Mt. Ida Drive</b>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALBERT John DORSEY</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Benevive BOARDLEY</b>  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>217-26-6224</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>LAURA MAKLE 3560 Apt D Mt Ida Dr.</b>   |                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>STAPHYLOCOCCAL SEPTICEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PRIMARY ADDISON'S DISEASE, MILIARY TB.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>PT. HAD 2 CARDIAC ARRESTS IN HOSPITAL</b>  |  |   |   |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                            |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>9/13</b> 19 <b>79</b> to <b>11/2</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/2</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (we) (did) (did not) view the body after death. |   | 22b. SIGNATURE<br><b>Evelyn Jackson MD</b>   |                            |  |
| 22c. DATE SIGNED<br><b>11/2/79</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EVELYN JACKSON, M.D.</b>  |   | 22e. ADDRESS<br><b>22 S. GREENE ST. BALT. MD</b>   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/7/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn</b>  |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard Co. Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>MORTON &amp; SONS</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1979</b>   |                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>History Laboratory</b>  |  | 25c. ADDRESS<br><b>1701 Laurens Street</b>  |   | 25d. REGISTRAR'S SIGNATURE   |                            |  |

BP



Simmonsville, Mo.

John

Genitive

no

Division



12/17/79 Great Town

Initial

1701 Lawrence Street

Howard Co.

NOV 1979

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 17 8257 11/30/79 83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 8 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                                   |   |   |                                   |  |  |
|---|--|--|--|---|-----------------------------------|---|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MYRTLE DORSEY</b>       |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>6</b> YEAR <b>79</b>         |   |                                   | 2b. HOUR<br><b>M</b>  |   |                                   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>3</b> YEAR <b>09</b>  |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                   |   |                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4017 W. Franklin St.</b> |  |   |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Balto</b>  |   | 13c. CITY OR TOWN<br><b>Balto</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Walter</b> MIDDLE <b>Evans</b> LAST |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Etta</b> MIDDLE <b>Bankers</b> LAST |   |                                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |   |                                   | 16b. SOCIAL SECURITY NO.<br><b>215 12 7607</b> |  |
| 17. INFORMANT<br><b>Mildred Dorsey</b>                            |  |  | 18. ADDRESS<br><b>Juanita Sappington</b>                                 |   |                                   | 19. CITY OR TOWN<br><b>4017 W. Frankl</b>   |   |                                   | 20. STATE<br><b>Md.</b>                        |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARCINOMA OF COLON**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**6 mo**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>AUG 25</b> , 19 <b>70</b> , to <b>NOV 6</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov 1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Frank G. Ruehn MD</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/7/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FRANK G RUEHN</b>   |  |  |  | 22e. ADDRESS<br><b>7600 OSLER DRIVE TOWSON MD</b>                                    |  |  |  |

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/9/79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Jas. A. Morton &amp; Sons</b><br>ADDRESS<br><b>1701 Laurens St</b> |  |                             |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1979</b>     |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                      |  |

(M)

100

New York

U.S.A.

N

4017 W. Franklin St.

Domestic

4017 W. Franklin St.

N

Balance

Mc.

Walter Evans

Miss Barbara

215 12 7607

4017 W. Franklin St.

no

100

100

Encl

11/10/70

Walter Evans

100

100



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE A "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |  |  |   |  |   |  | REG. NO. 27286  |  |                      |  |
|---|--|------------------|--|--|--|---|--|---|--|---|--|----------------------|--|
| 1. FOR STATE REGISTRAR  |  |                  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR             |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>(Maybell) Mae Bell Dow  |  |                  |  |  |  |   |  |   |  | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11 20 19 79         |  | 2b. HOUR<br>9:11 P M |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 16 1911                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                  |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                             |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |                      |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |                  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                               |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital                     |  |   |  |                      |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |   |  |   |  |   |  |                      |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                  |  |  |  |   |  |   |  |   |  |                      |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY<br>Baltimore   |  |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br>1101 Druid Hill Avenue                                       |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ellick Clark  |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Belle Robinson |  |   |  |   |  |   |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>220-24-4933                              |  |   |  | 17. INFORMANT ADDRESS<br>Ernest Clark, Sr. 2032 West Saratoga Street  |  |   |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease<br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |                  |  |  |  |   |  |   |  |   |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |  |  |   |  |   |  |   |  |                      |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                    |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19           |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)          |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |  |  |   |  |   |  |   |  |                      |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan   |  |                  |  | TITLE (SPECIFY)<br>Assistant   |  |   |  | DATE SIGNED<br>11/21/79   |  |   |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |  |                  |  | ADDRESS<br>111 Penn Street   |  |   |  |   |  |   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>11/26/1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cemetery |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                   |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 East North Avenue   |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1979                |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |  |                      |  |

5. *Conclusions*

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEO F. DRESCHER  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 22 79 |   |  | 2b. HOUR<br>2:53 P.M.   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 21 04  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. City Hospitals |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>foreman                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>ESSKAY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3638 Roberts Place    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick Drescher  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Hartman  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No            |  |  |   | 16b. SOCIAL SECURITY NO.<br>213-03-9165A  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Mary Drescher - 3638 Roberts PI                                |  |  |  |

## MEDICAL CERTIFICATION

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CARDIAC ARREST                                 |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 hr |  |
| 410-<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) MYOCARDIAL INFARCTION |  | 1 hr  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) CARDIOVASCULAR DISEASE   |  | YEARS   |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

|  |  |                                      |  |                              |  |
|--|--|--------------------------------------|--|------------------------------|--|
| 22b. SIGNATURE<br>Bradley S. Bender                        |  | DEGREE<br>MD                         |  | 22c. DATE SIGNED<br>11/22/79 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bradley S. Bender |  | 22e. ADDRESS<br>Balto City Hospitals |  |                              |  |

|  |  |                       |  |  |  |   |  |
|--|--|-----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>11-26-79 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oaklawn Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. City MD. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ZANNINO FUNERAL HOME   |  |                       |  | ADDRESS<br>CONKLIN + GOLGA ST.                     |  | 25. NOV 26 1979<br>H-22-79                                    |  |



NOV 19 1964  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  | REG. NO. 7 9 2 7 2 8 8                    |  |
|---|--|--|--|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>JOSEPH, FRANK DRESSSEL JR.  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 29 79                           |  |   | 2b. HOUR<br>2 PM   |  |  |  |   |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>CAUCASIAN  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>08 28 15   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |  | 7a. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  | 7b. UNDER 24 HRS<br>MONTHS DAYS HOURS MIN |  |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7d. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PIPE FITTER   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MD. DRYDOCK |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>605 N. ROSE ST. |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOSEPH F. DRESSAL SR.  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>AMELIA -----             |  |   |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>214019130  |  | 17 INFORMANT ADDRESS<br>JOANNE DIEHL 627 N. BELNORD AVE.   |   |  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Pulmonary Emboli, massive, bilateral<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerosis, generalized with<br>thrombotic occlusion of right coronary artery<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |   |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Anthony A. ARZ, MD</i>   |  |  | DEGREE<br>MD   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>11/29/79                     |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Anthony A. ARZ, MD   |  |  | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229                    |  |   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |  | 23b. DATE<br>12/3/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John. Wood  |  |  | ADDRESS<br>1211 Chesaco Ave.   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 6 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony A. ARZ</i>  |  |   |  |

(RECEIVED)

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

505 N. W. 10th St.

BALTIMORE

MARYLAND

RECEIVED

ST. AGNES HOSPITAL, BALTIMORE, MD.

X

505 N. W. 10th St. BALTIMORE, MD.

RECEIVED

BALTIMORE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/73  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

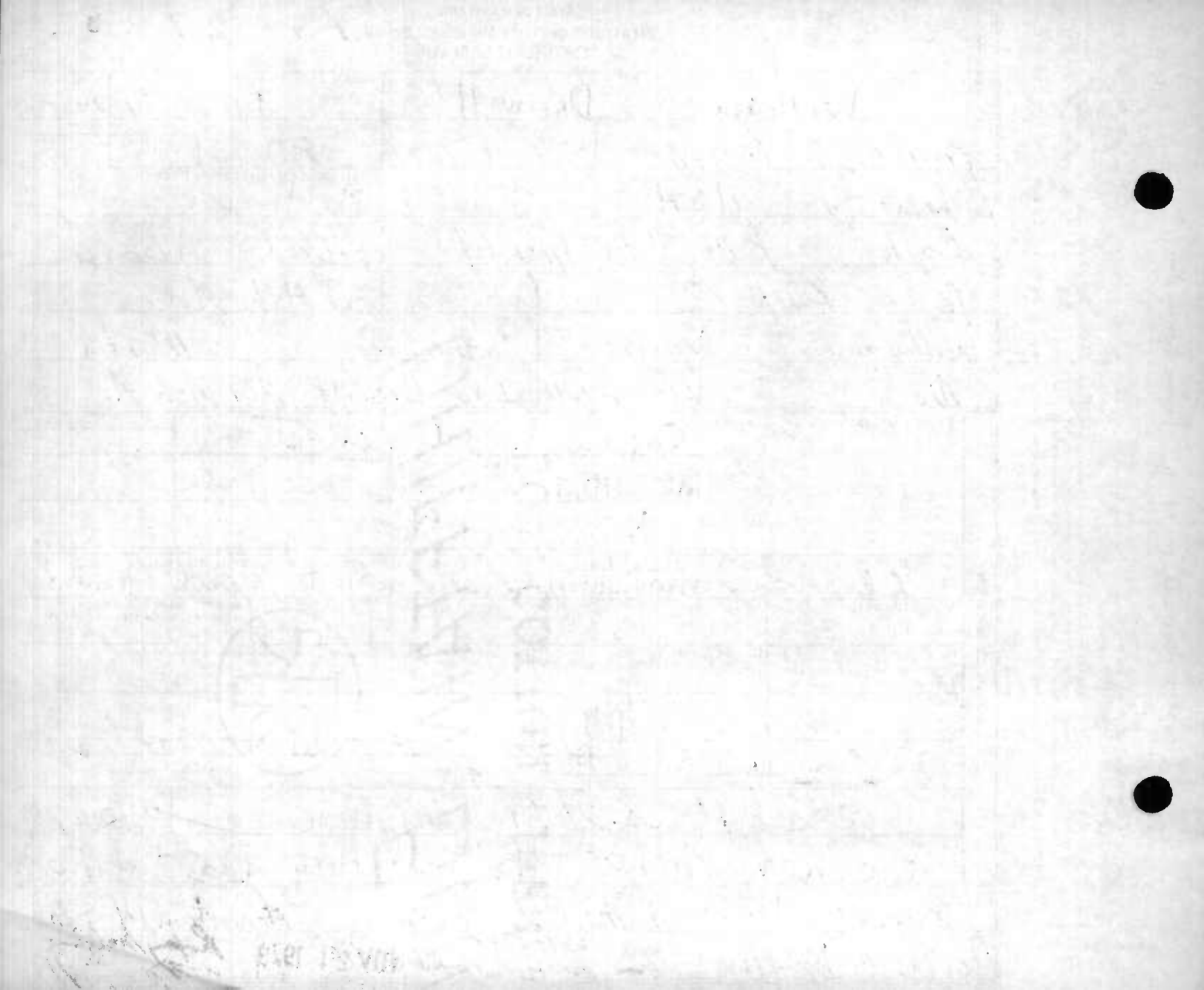
7 9 2 7 2 8 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William DREWITT   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 20 79   |  | 2b. HOUR<br>345A <sub>M</sub>                |
| 3. SEX<br>male  | 4. RACE<br>Negro   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 11 1899  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Richmond Va.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>Balt.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balt. City Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Laborer |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md. Balt.   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Drewitt   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Martin                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-07-4046  |   | 17. INFORMANT<br>ADDRESS<br>Ida Drewitt 201 Ash Ave.                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a):<br>3314 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) } Cardiorespiratory arrest<br>intermittent pressure hydrocephalus<br>(c) } DUE TO, OR AS A CONSEQUENCE OF<br>hypertension<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION, GIVEN IN PART 1 (a)<br>Chronic ethanolism, seizure activity, syphilis (treated)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (this hospital) attended the deceased from 8/12/1979, to Nov. 20, 1979, that (we) last saw the deceased alive on Nov 20 1979, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) (it) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br>Richard Barnett MD  |  | DEGREE  |   | 22c. DATE SIGNED<br>11/20/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Barnett  |  | 22e. ADDRESS<br>Balt City Hosp. Dept of Med.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11-23-79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem                          |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Md   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1979  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Carlton C. Douglas  |  | ADDRESS<br>669-1738<br>103 Arundel  |   | 25b. REGISTRAR'S SIGNATURE<br>Ruthie McHenry                                   |  |

MEDICAL CERTIFICATION



2731 BP  
DHMM-16 20M  
(VRA 15, 4) 7/78

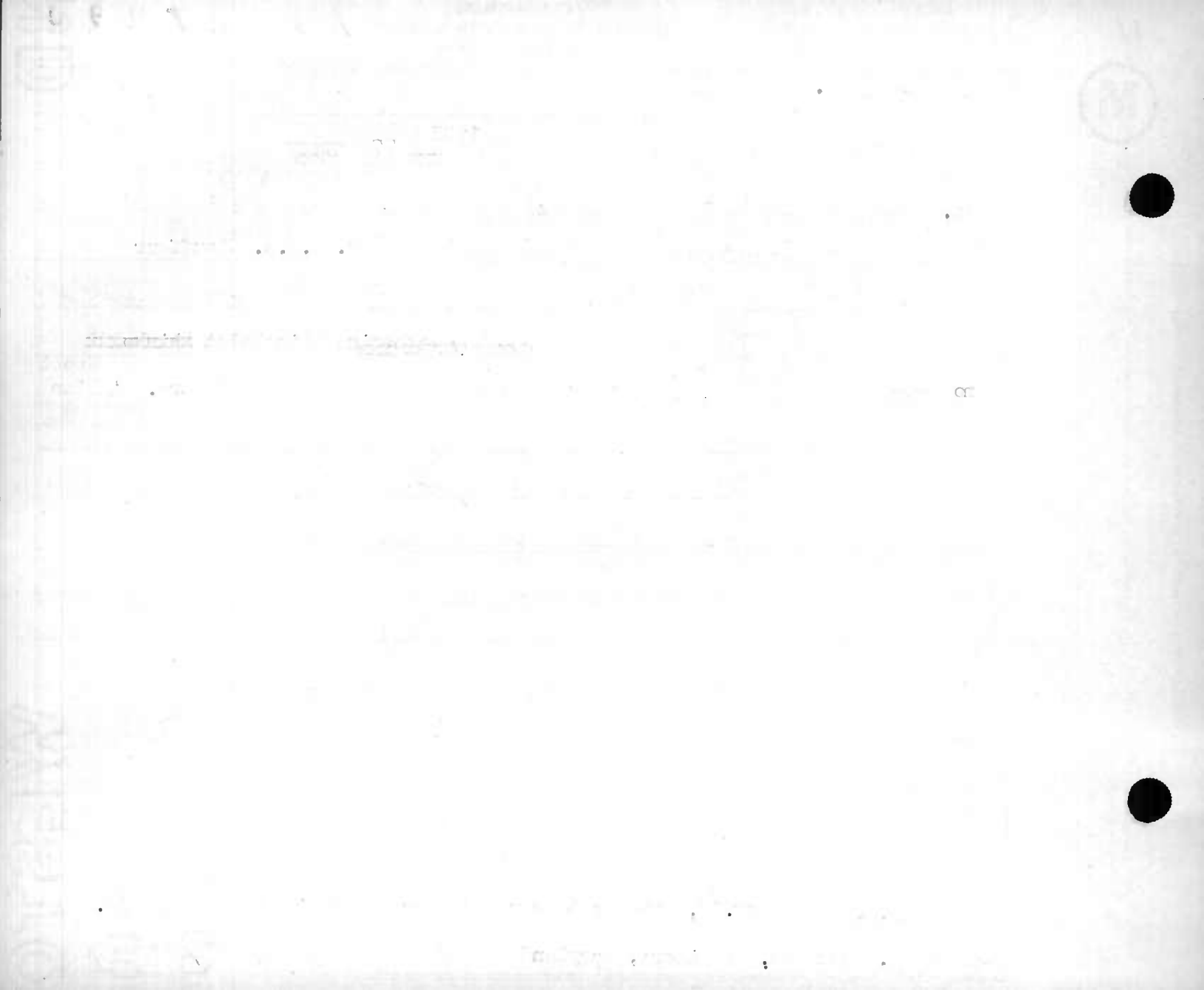
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 9 2 7 2 9 0  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>John Drost</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11/12/79</b>   |  |   |  |
| 3. SEX <b>Male</b>   |  |   |  | 2b. HOUR <b>5:22 P</b> M   |  |   |  |
| 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 25 1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS  |  | 7. UNDER 1 YEAR MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING (FE) INDUSTRY) <b>Ret. M.T.A. Chauffeur</b>  |  | 12b. KIND OF BUSINESS OR  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>   |  | 13b. COUNTY <b>Balto.</b>   |  | 13c. CITY OR TOWN <b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Julius Drost</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kath. Catherine Rhineholdt Rhineholdt</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>216-03-3740</b>   |  |
| 17. INFORMANT ADDRESS <b>Drost</b>   |  | 17. INFORMANT <b>Pt. Medical Chart</b>  |  | 17. INFORMANT <b>Mrs. Lillian</b>  |  | 17. INFORMANT <b>Drost</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio - Respiratory Arrest.</b><br><b>410 -</b><br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last:<br>(b) <b>Post Myocardial Infarction</b><br>(c) <b>Severe Congestive Heart Failure see to (b)</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/04/79</b> 19 <b>79</b> , to <b>11/12</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/12/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Anusha Khianey</b> DEGREE  |  |   |  | 22c. DATE SIGNED <b>11/12/79</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANUSHA KHIANEY</b>  |  |   |  | 22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>Nov. 16, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b> ADDRESS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |





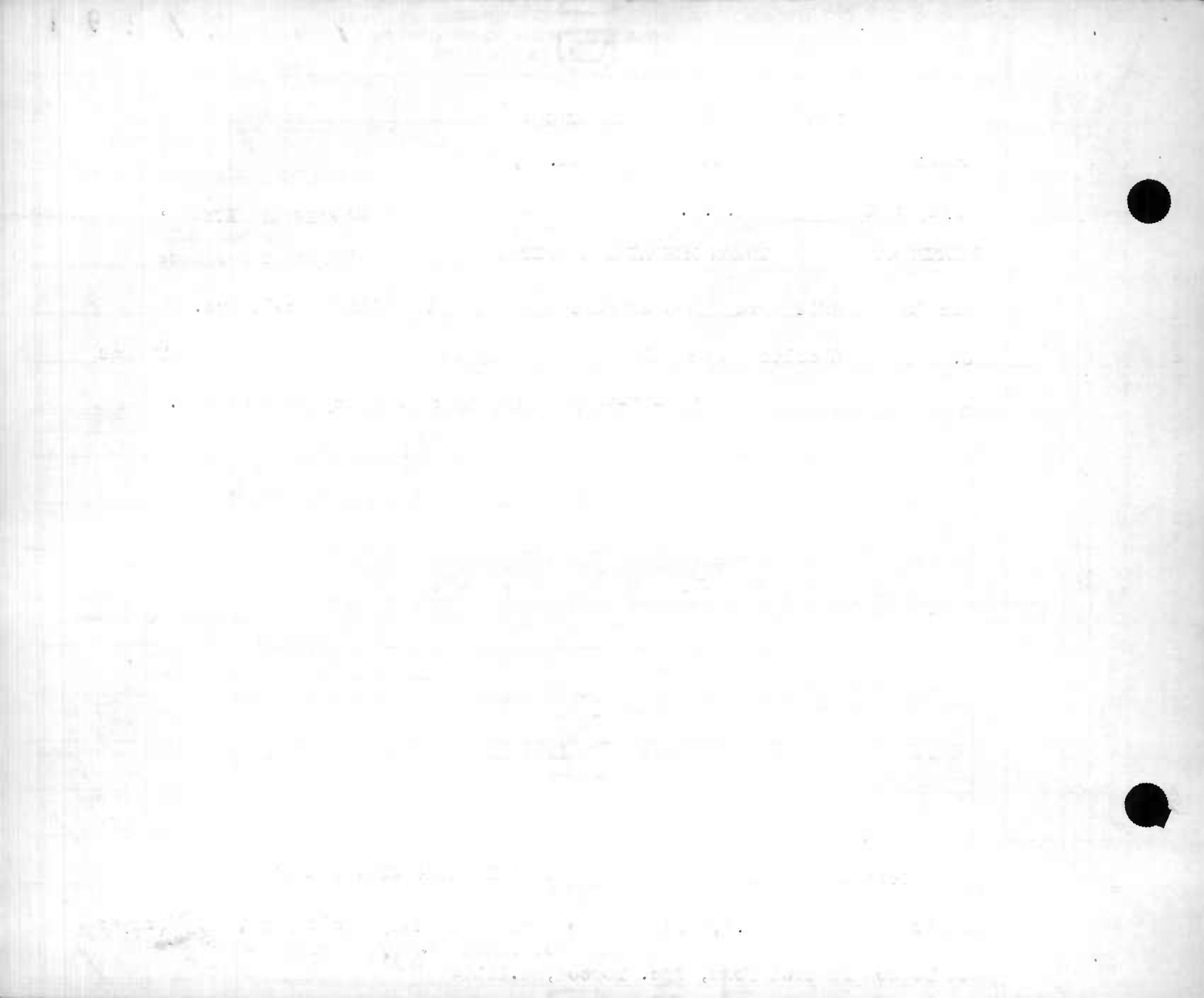


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 9 2 7 2 9 1   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>MARY M DUGAN</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 2 79</b>   |  | 2b. HOUR<br><b>4:45 A.M.</b>   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 6, 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Blueprint Business</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Lutherville</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>J. Charles Mac gill</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Thomas</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-32-2665</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mary Dugan Shipley Same as #13.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prob Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pancreatic cancer (Probable)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>1579</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>COPD, Hx of CHF, S/P RCVA</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/2/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/2</b> 19 <b>79</b> to <b>11/2</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/2</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Gregory O. Faith, MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/2/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GREGORY O FAITH</b>  |  |   |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Nov. 3, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  | ADDRESS<br><b>1050 York Road</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 6 1979</b>  |  | 25b. SIGNATURE OF REGISTRAR  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 REG. NO. 27292

FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EPPA DURHAM</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-1-79</b>                   |  | 2b. HOUR<br><b>11:40 PM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-31-00</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>             |  | 8. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto CITY</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN Hosp</b>  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dental Tech</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                       |  | 13a. STREET ADDRESS<br><b>5219 CATALPHA RD</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert M Stubbs Sr</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Seyfer</b> |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-22-8523</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Jean Wagster 5219 Catalpha Rd</b>    |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ISCHEMIC CARDIOMYOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/22/79</b> to <b>11/1/79</b> , that (I) (we) last saw the deceased alive on <b>11/1/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>11/1/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HASMUKH R PATEL</b>   |  | 22e. ADDRESS<br><b>5601 LOCHR RAIVER BLVD</b>                           |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |
| 23b. DATE<br><b>11/5/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 2 1979</b>                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.



RECEIVED

1944



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 9 3

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROSETTA DUR 4 AM</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 21 79</b> |   |  | 2b. HOUR<br><b>5 58 PM</b>   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>02 12 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> (MD)   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DRESSMAKER</b>                                      |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. STREET ADDRESS<br><b>4514 Belview Ave</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Junius FOSTER</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Charlotte Epps</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><b>JAMES Durham 4514 Belview Ave.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MULTIPLE CARDIAC ARRHYTHMIAS</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MASSIVE MYOCARDIAL INFARCT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>ALLERGIES TO QUINIDINE, PROTESTYL, LIDOCAINE</b>   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/07</b> , 19 <b>79</b> , to <b>11/21</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>R. J. Albrecht MD</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/21/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RJ ALBRECHT</b>   |  |   |   | 22e. ADDRESS<br><b>SINAI HOSP</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/26/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BA KO MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Jas A. Morton 1701 LAURENS ST.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

35  
42  
35  
200  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

7 9

2 7

2 9

4

1- FOR  
STATE  
REGISTRAR

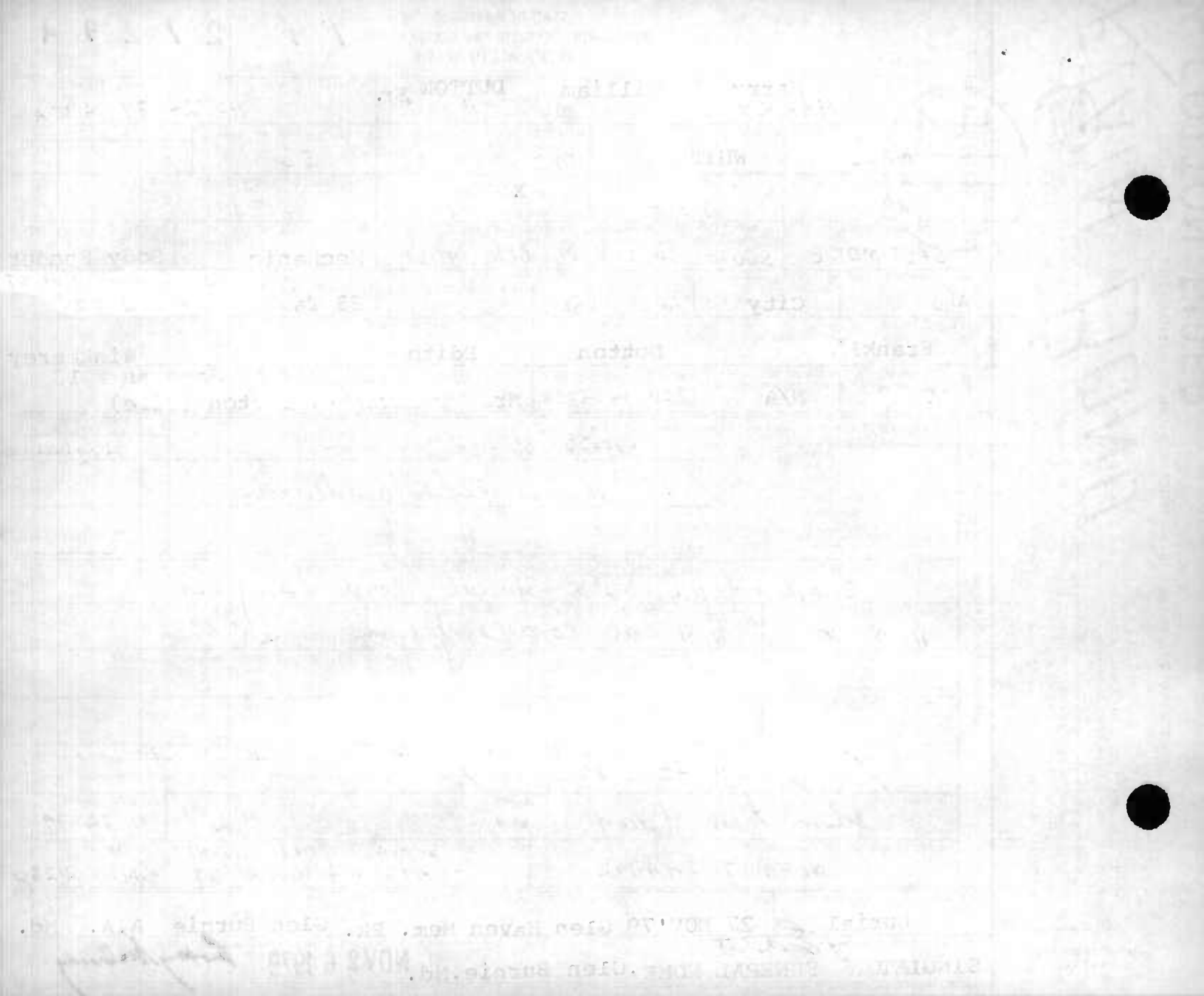
REG. NO.

|  |   |   |   |   |   |   |  |   |  |   |  |
|--|---|---|---|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST <b>Harry</b><br><b>HARRY</b>  | MIDDLE <b>William</b><br><b>WILLIAM</b> | LAST <b>DUTTON</b><br><b>DUTTON</b>   | 2a. DATE OF DEATH   |   | MONTH <b>11</b>  | DAY <b>24</b>   | YEAR <b>79</b>                                   | 2b. HOUR<br><b>4:30 A.M.</b>                                      |  |
| 3 SEX<br><b>MALE</b>   | 4 RACE<br><b>WHITE</b>                        | 5. DATE OF BIRTH  |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |   | IF UNDER 1 YEAR<br>MONTHS <b>53</b> DAYS <b>YRS</b>  |   | IF UNDER 24 HRS<br>HOURS <b>4</b> MIN. <b>30</b> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GENL. HOSP.</b>             |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Body &amp; Fender</b> |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>33 Talbott Street</b>  |   | 13f. CITY OR TOWN<br><b>21225</b>                |   |  |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>City</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   |   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Franklin</b> MIDDLE <b>Dutton</b> LAST <b>Dutton</b>   |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Edith</b> MIDDLE <b>Winkmeyer</b> LAST <b>Winkmeyer</b>  |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220-14-3320</b>  |   | 17. INFORMANT<br><b>Mrs. Delores R. Dutton (wife)</b>   |   | ADDRESS <b>Same as # 13</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic shock</b><br><b>5130</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Abscess Right Middle lobe</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Quadruplegia, 2<sup>nd</sup> 16 Spinal Cord compression</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Quadruplegia, 2<sup>nd</sup> 16 Spinal Cord compression</b> |   |   |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 hrs.</b> |  |
| 19a. DATE OF OPERATION<br><b>11-15-79</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Spinal Cord Compression</b>  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>11-08-79</b> to <b>11-15-79</b> , that (I) (we) lost saw the deceased alive on <b>11-24-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |   |   |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>MEHM T. THAVANG</b>   |   |   |   | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><b>11-24-79</b>                           |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MEHM T. THAVANG</b>  |   |   |   | 22e. ADDRESS<br><b>S. BALTIMORE GENL HOSP.<br/>3001S, HANOVER ST. BALTO 21230</b>   |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>27 NOV '79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk. Glen Burnie A.A. Md.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SINGLETON FUNERAL HOME</b> ADDRESS <b>Glen Burnie, Md.</b>   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |  |   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY FILE IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
|--|---------|---|--|---|--|---|--|-----------------------------------|--|--------------------------|-------|--|--|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH                 |  | KNOWN<br>ESTIMATED       | MONTH | DAY  | YEAR   | 2b. HOUR |
| WILLIAM  |         | Dwyer   |  |   |  |   |  | 11                                |  |                          | 28    | 79   |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                  |  | 2c. DATE PRONOUNCED DEAD |       | MONTH  | DAY  | YEAR     |
| male   | white   |   |  | YRS.  |  | MONTHS  |  | DAYS                              |  | 11                       |       | 28   | 79   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED   |  | WIDOWED                           |  | DIVORCED                 |       | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |          |
| Baltimore  |         |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  | Baltimore City           |       |  |  |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |  | Baltimore                         |  |                          |       |  |  |          |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                      |  | 13e. STREET ADDRESS               |  |                          |       |  |  |          |
| Md.  |         |   |  | Balto.  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 11 Clement Street                 |  |                          |       |  |  |          |
| 14. FATHER'S NAME  |         | MIDDLE  |  | LAST  |  | 15. MOTHER'S MAIDEN NAME                                      |  | MIDDLE                            |  | LAST                     |       |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS   |  |                                   |  |                          |       |  |  |          |
| (YES, NO, OR UNKNOWN)  |         | (IF YES, GIVE WAR OR DATES)                                 |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |  |   |  |   |  |                                   |  |                          |       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART I DEATH WAS CAUSED BY: <b>Bronchopneumonia</b>  |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| IMMEDIATE CAUSE (a) <b>485-</b>  |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| (c)  |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| <b>fatty liver</b>   |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |   |  |                                   |  |                          |       | 20. AUTOPSY?   |  |          |
|  |         |   |  |   |  |   |  |                                   |  |                          |       | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 21a. EXTERNAL CAUSE WAS  |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED                                      |  | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)          |  |                                   |  |                          |       |  |  |          |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | HOUR A.M. MONTH DAY YEAR                                    |  | P.M. 19   |  |   |  |                                   |  |                          |       |  |  |          |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  | CITY OR TOWN COUNTY STATE                                     |  |                                   |  |                          |       |  |  |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |   |  | STREET  |  |   |  |                                   |  |                          |       |  |  |          |
| 22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |  | DATE  |  | 11/29/79  |  |                                   |  |                          |       |  |  |          |
| Margarita A. Korell  |         | Assistant   |  | MEDICAL EXAMINER  |  | SIGNED  |  |                                   |  |                          |       |  |  |          |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |  | 111 Penn Street   |  |   |  |                                   |  |                          |       |  |  |          |
| Margarita A. Korell, M.D.  |         |   |  |   |  |   |  |                                   |  |                          |       |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                            |  | 23d. LOCATION   |  | COUNTY STATE                      |  |                          |       |  |  |          |
| Removal  |         | 12/5/79   |  |   |  | CITY OR TOWN  |  |                                   |  |                          |       |  |  |          |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE                                    |  |   |  |                                   |  |                          |       |  |  |          |
| NAME   |         | ADDRESS   |  | DEC 7 1979  |  |   |  |                                   |  |                          |       |  |  |          |
| Anatomy Board  |         | Balto., Md.   |  |   |  |   |  |                                   |  |                          |       |  |  |          |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 2 9 6

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>STANLEY (STANISLAW) DZIEWANOWSKI</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 4, 1979</b> |   |  | 2b. HOUR<br><b>10:25</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 10 1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BALTIMORE CITY</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>817 EATON ST.</b>  |  |

|   |  |  |  |
|---|--|--|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BRONISLAW DZIEWANOWSKI</b>           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>WIKADYSLAWA SIATKOWSKI</b> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO<br><b>320 03 8761</b>                                  |  |
| 17. INFORMANT<br>ADDRESS<br><b>ADAM DZIEWANOWSKI 3925 KYNDALE AVE</b>             |  |  |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arrhythmia - Ventricular fibrillation</b><br><b>4149</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>severe ischemic heart dz</b><br>(c) <b>severe ischemic heart dz</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> 19 <b>77</b> , to <b>11/4</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/4</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |

|   |  |   |  |                                    |  |
|---|--|---|--|------------------------------------|--|
| 22b. SIGNATURE<br><b>Michael J. Ryan</b>                        |  | DEGREE  |  | 22c. DATE SIGNED<br><b>11/4/79</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael J. Ryan</b> |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b> |  |                                    |  |

|  |  |                                  |  |  |  |   |  |
|--|--|----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>               |  | 23b. DATE<br><b>11/9/79</b>      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART OF JESUS</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b> |  |
| 24a. FUNERAL DIRECTOR<br>NAME<br><b>RAYMOND L. KACZOROWSKI</b> |  | ADDRESS<br><b>2525 FLEET ST.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1979</b>                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                  |  |

10-11-55

NOVEMBER 11, 1955

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THE JOINTS HOSPITAL



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |                              |  |  |  |   |  |   |                                   |                  |  |  |  |  |  |
|---|--|------------------------------|--|--|--|---|--|---|-----------------------------------|------------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                              | FIRST MIDDLE LAST  |  |  | 2a. DATE KNOWN OF DEATH                                       |  |   | MONTH DAY YEAR                    |                  |  | 2b. HOUR   |  |  |  |
| OSCAR   |  |                              | EADDY  |  |  | 11  |  |   | 18                                |                  |  | 79   |  |  |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |                                   | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD   |  |  |  |
| male  |  | black                        |  | DEC 28 1905  |  | 73  |  | MONTHS  |                                   | DAYS             |  | HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED   |  | NEVER MARRIED   |  | WIDOWED   |                                   | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| N.C.  |  | USA                          |  | -  |  | -   |  | -   |                                   | -                |  | Baltimore City   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |                  |  |  |  |  |  |
| Baltimore   |  |                              | University Hospital                                      |  |  | RETIRED   |  |   | STEAMSHIP TRA                     |                  |  |  |  |  |  |
| 13a. STATE  |  |                              |  | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN   |                                   |                  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |
| MD  |  |                              |  | BALTIMORE  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                                   |                  |  | 13e. STREET ADDRESS  |  |  |  |
| 14. FATHER'S NAME   |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |                                   |                  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |
| -   |  |                              |  | -  |  |   |  | No  |                                   |                  |  | 220-09-9463  |  |  |  |
| 17. INFORMANT   |  |                              |  | ADDRESS  |  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)     |                                   |                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| -   |  |                              |  | -  |  |   |  | Willie M. Scott-2607 Garrison Blvd.   |                                   |                  |  | PART 1 DEATH WAS CAUSED BY:  |  |  |  |
| 4292  |  |                              |  | IMMEDIATE CAUSE (a)  |  |   |  | Arteriosclerotic cardiovascular disease                                       |                                   |                  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |                              |  | (b)  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF  |                                   |                  |  | (c)  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |                              |  | 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |                                   |                  |  | 20. AUTOPSY?   |  |  |  |
| -   |  |                              |  | -  |  |   |  | -   |                                   |                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                 |  |                              |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                   |                  |  | 21d. INJURY OCCURRED   |  |  |  |
| -   |  |                              |  | HOUR A.M. MONTH DAY YEAR   |  |   |  | -   |                                   |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  |
| 21f. LOCATION   |  |                              |  | 21g. PLACE OF INJURY   |  |   |  | 21h. LOCATION   |                                   |                  |  | 21i. LOCATION  |  |  |  |
| -   |  |                              |  | -  |  |   |  | -   |                                   |                  |  | -  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |                              |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |   |  | death resulted from:  |                                   |                  |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE  |  |                              |  | TITLE (SPECIFY)  |  |   |  | DATE SIGNED   |                                   |                  |  | 11/19/79   |  |  |  |
| Margarita A. Korell   |  |                              |  | M.D. Assistant   |  |   |  | -   |                                   |                  |  | -  |  |  |  |
| EXAMINER'S NAME   |  |                              |  | ADDRESS  |  |   |  | 23a. BURIAL, CREMATION, REMOVAL   |                                   |                  |  | 23b. DATE  |  |  |  |
| Margarita A. Korell, M.D.   |  |                              |  | 111 Penn Street  |  |   |  | Burial  |                                   |                  |  | 11/21/79   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |                              |  | 23d. LOCATION  |  |   |  | 23e. DATE REC'D. BY REGISTRAR   |                                   |                  |  | 23f. REGISTRAR'S SIGNATURE   |  |  |  |
| Mt. Auburn Cem.   |  |                              |  | Baltimore, Md.   |  |   |  | NOV 20 1979   |                                   |                  |  | -  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |                              |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |                                   |                  |  | 25c. DATE REC'D. BY REGISTRAR  |  |  |  |
| VERNON R. BAILEY -1348 N. CALHOUN ST. -21217  |  |                              |  | -  |  |   |  | -   |                                   |                  |  | -  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

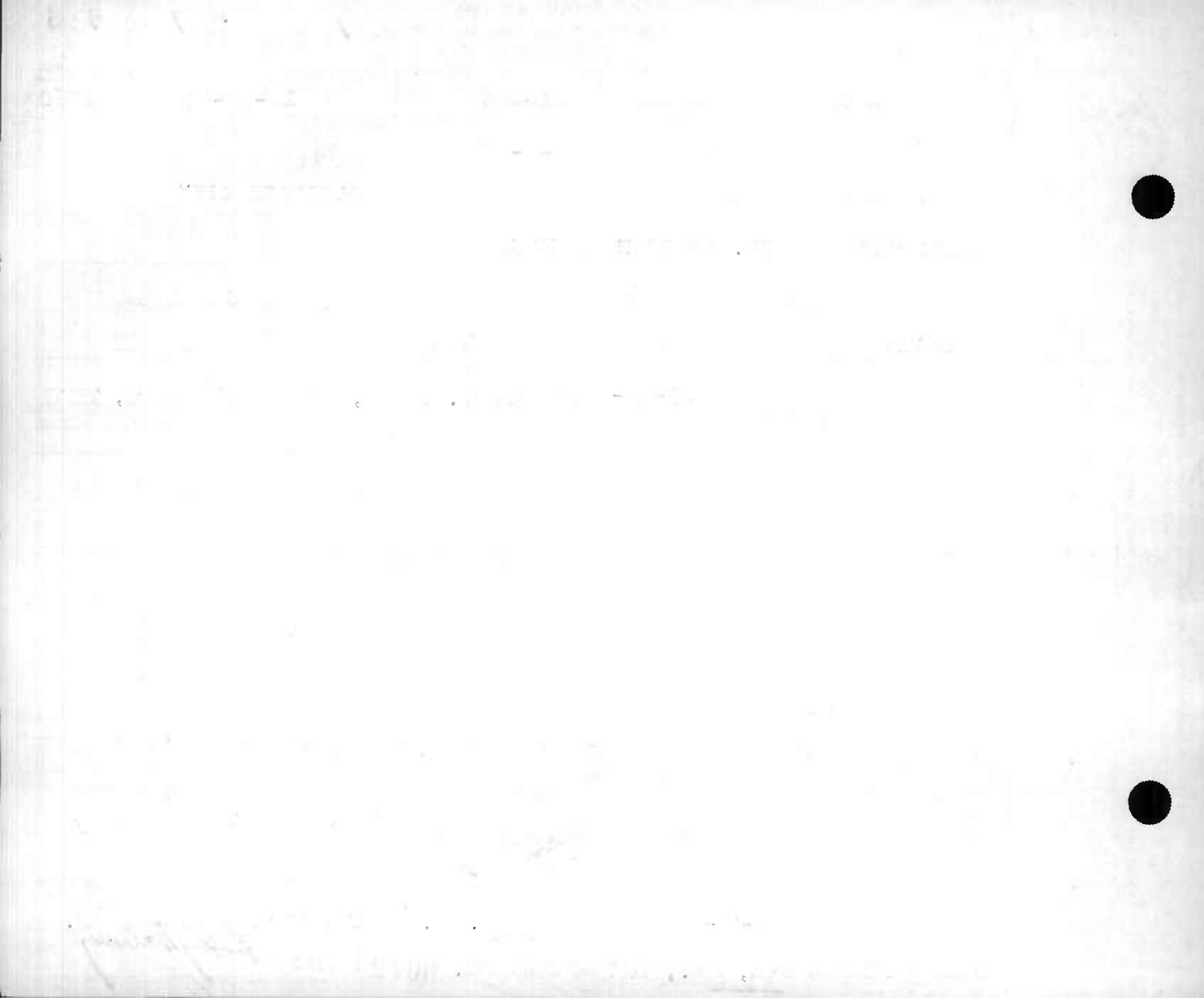
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |        |  |   | 7 9 2 7 2 9 8  |                |  |          |                                   |  |  |  |
|---|--|--|--|--|--|--|--------|--|---|--|----------------|--|----------|-----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.   |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR |  | 2b. HOUR |                                   |  |  |  |
| GRACE   |  |  | I  |  |  |  | EASLEY |  | 11-19-79  |  |                |  | 1750     |                                   |  |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |        |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |                | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS                   |  |  |  |
| FEMALE  |  |  | WHITE  |  |  | 7-8-05   |        |  | 74  |  |                | MONTHS DAYS  |          | HOURS MIN.                        |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.          |  |                |  |          |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |        |  |   |  |                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |          | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| BALTIMORE   |  |  | ST. AGNES HOSPITAL   |  |  |  |        |  |   |  |                | HOMEMAKER  |          |                                   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| 13a. STATE  |  |  | 13b. CITY OR TOWN  |  |  | 13c. INSIDE CITY LIMITS?   |        |  | 13d. STREET ADDRESS   |  |                |  |          |                                   |  |  |  |
| MD  |  |  | BALTO  |  |  | BALTO  |        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                | 815 FRANCIS AVENUE   |          |                                   |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME                         |  |        |  |   |  |                |  |          |                                   |  |  |  |
| FIRST MIDDLE LAST   |  |  |  |  | FIRST MIDDLE LAST                                |  |        |  |   |  |                |  |          |                                   |  |  |  |
| LOUIS   |  |  |  |  | SIEBEL   |  |        |  |   | CARRIE DUKEHART  |                |  |          |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO.                         |  |        |  |   | 17. INFORMANT ADDRESS  |                |  |          |                                   |  |  |  |
| NO  |  |  |  |  | 213-64-0472                                      |  |        |  |   | CLYDE T. TURNER, 817 FRANCIS AVENUE, 21227                                     |                |  |          |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>   |  |  |  |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| 1991 } DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| (b) <u>Terminal Ca - metastasis</u>   |  |  |  |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| (c) <u>4 months</u>   |  |  |  |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |        |  |   | 20a. AUTOPSY?  |                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |                                   |  |  |  |
|   |  |  |  |  |  |  |        |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |                                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY                              |  |        |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                |  |          |                                   |  |  |  |
|   |  |  |  |  | HOUR A.M. MONTH DAY YEAR                         |  |        |  |   |  |                |  |          |                                   |  |  |  |
|   |  |  |  |  | P.M. 19  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  |  | 21e. PLACE OF INJURY                             |  |        |  |   | 21f. LOCATION  |                |  |          |                                   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |  |        |  |   | CITY OR TOWN COUNTY STATE  |                |  |          |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-16</u> 19 <u>78</u> , to <u>11-19</u> 19 <u>78</u> , that (I) (we) last saw the deceased alive on <u>11-19</u> 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death. |  |  |  |  |  |  |        |  |   |  |                |  |          |                                   |  |  |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE   |  |        |  |   | 22c. DATE SIGNED   |                |  |          |                                   |  |  |  |
| <u>Huan-Jane Hsu</u>  |  |  |  |  |  |  |        |  |   | 11-19-78   |                |  |          |                                   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  | 22e. ADDRESS                                     |  |        |  |   |  |                |  |          |                                   |  |  |  |
| <u>Huan-Jane Hsu</u>  |  |  |  |  | <u>St. Agnes Hosp</u>                            |  |        |  |   |  |                |  |          |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |        |  | 23d. LOCATION   |  |                | COUNTY STATE   |          |                                   |  |  |  |
| BURIAL  |  |  | 11-21-79   |  |  | LAKE VIEW MEM. PK.   |        |  | SYKEVILLE   |  |                | CARROLL MD.  |          |                                   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  | ADDRESS  |  |        |  |   | 25a. DATE REC'D. BY REGISTRAR  |                | 25b. REGISTRAR'S SIGNATURE                                     |          |                                   |  |  |  |
| HUBBARD FUNERAL HOME, INC.,   |  |  |  |  | 4107 WILKENS AVE.                                |  |        |  |   | NOV 21 1979  |                | <u>Robert A. Brady</u>   |          |                                   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CARRINGTON R. EAST</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-7-79</b>  |  | 2b. HOUR<br><b>2:45 P.M.</b>  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2-15-06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>73</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ARKANSAS</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN Hospital of Md</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE)<br><b>Tool &amp; Machine</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ship Bldg.</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ROBERT THOMAS EAST</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SOULA EAST</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |   |  |
| 17. SOCIAL SECURITY NO.<br><b>214-105-640</b>   |  | 18. INFORMANT ADDRESS<br><b>Mrs. Evelyn L. East Same as # 13</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic lung Ca -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Bruce A. Bunnenthal MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/7/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bruce A. Bunnenthal MD</b>  |  |  |  | 22e. ADDRESS<br><b>Lutheran Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/10/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>MacNabb Funeral Home</b>  |  |  |  | ADDRESS<br><b>Catonville, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1979</b>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME   |       | 3. SEX |  | 4. RACE |   | 5. DATE OF BIRTH  |      | 6. AGE (IN YEARS LAST BIRTHDAY)      |   | 7. BALTIMORE CITY OR COUNTY OF DEATH |  |
|--|-------|--------|--|---------|---|---|------|--------------------------------------|---|--------------------------------------|--|
| (TYPE OR PRINT)  | FIRST | MIDDLE | LAST   |         |   | MONTH   | DAY  | YEAR                                 | IF UNDER 1 YEAR   | IF UNDER 24 HRS.                     |  |
| DAVID  | L.    | EATON  | M  | W       | 5 | 12  | 1915 | 64                                   | YRS.  |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |       |        | 7b. CITIZEN OF WHAT COUNTRY?   |         |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                                      |  |
| State College Pa.  |       |        | USA  |         |   |   |      | BALTIMORE City MD.                   |   |                                      |  |
| 10. CITY OR TOWN OF DEATH  |       |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |         |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |      |                                      | 12b. KIND OF BUSINESS OR INDUSTRY   |                                      |  |
| Baltimore  |       |        | SINAI HOSPITAL OF BALTO  |         |   | Retired C & P Telephone   |      |                                      |   |                                      |  |
| 13a. STATE   |       |        | 13b. CITY OR TOWN  |         |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |      |                                      | 13e. STREET ADDRESS   |                                      |  |
| Md.  |       |        | Balto.   |         |   | Reisterstown  |      |                                      | 115 Chartley Drive  |                                      |  |
| 14. FATHER'S NAME  |       |        | 15. MOTHER'S MAIDEN NAME   |         |   |   |      |                                      |   |                                      |  |
| David  |       |        | Eaton  |         |   | Gwendolyn   |      |                                      | Davis   |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |       |        | 16b. SOCIAL SECURITY NO.   |         |   | 17. INFORMANT   |      |                                      | ADDRESS   |                                      |  |
| Yes  |       |        | WW 2   |         |   | 214-16-3782   |      |                                      | Mrs. R. Lucille Eaton Reisterstown, Md.   |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.  |       |        |  |         |   |   |      |                                      |   |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST IN SLEEP   |       |        |  |         |   |   |      |                                      |   |                                      | IMMEDIATE                                    |
| 410 - DUE TO, OR AS A CONSEQUENCE OF (b) EXTENSIVE MI, age undetermined.   |       |        |  |         |   |   |      |                                      |   |                                      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |       |        |  |         |   |   |      |                                      |   |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD   |       |        |  |         |   |   |      |                                      |   |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |       |        |  |         |   |   |      |                                      |   |                                      |  |
| Viral gastro-enteritis   |       |        |  |         |   |   |      |                                      |   |                                      |  |
| 19a. DATE OF OPERATION   |       |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |         |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |      |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |       |        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |      |                                      |   |                                      |  |
|  |       |        | P.M. 19  |         |   |   |      |                                      |   |                                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |       |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |         |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |      |                                      |   |                                      |  |
|  |       |        |  |         |   |   |      |                                      |   |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-19-79 to 11-20-79, that (I) (we) lost saw the deceased alive on 11-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |       |        |  |         |   |   |      |                                      |   |                                      |  |
| 22b. SIGNATURE   |       |        | DEGREE   |         |   | 22c. DATE SIGNED  |      |                                      |   |                                      |  |
| PETER GROSZMAN   |       |        |  |         |   |   |      |                                      |   |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |       |        | 22e. ADDRESS   |         |   |   |      |                                      |   |                                      |  |
| PETER GROSZMAN   |       |        | 600 REISTERSTOWN RD  |         |   |   |      |                                      |   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC)   |       |        | 23b. DATE  |         |   | 23c. NAME OF CEMETERY OR CREMATORY  |      |                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE   |                                      |  |
| Burial   |       |        | 11/23/79   |         |   | Evergreen Memorial Parkwood Cemetery  |      |                                      | Baltimore County, Md.   |                                      |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |       |        |  |         |   | 25a. DATE REC'D. BY REGISTRAR   |      |                                      | 25b. REGISTRAR'S SIGNATURE  |                                      |  |
| Eline Funeral Home Reisterstown, Md. 21136   |       |        |  |         |   | NOV 23 1979   |      |                                      |   |                                      |  |

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |                                    |  |   |  |   |  |
|--|--|--|---|--|------------------------------------|--|---|--|---|--|
| <div style="text-align: right;">7 9 2 7 3 0 1</div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b><br/>           FOR STATE REGISTRAR         </div>  |  |  |   |  |                                    |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |   |  | 2a. DATE OF DEATH                  |  |   |  |   |  |
| FREDERICK JOHN ECKES   |  |  |   |  | 11 6 79 10:00 AM                   |  |   |  |   |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR   |   |  |
| Male   |  | White  |   | 05 03 1897   |                                    | 82 YRS   |   | MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |   |  |
| Maryland   |  | USA  |   |  |                                    | Baltimore City MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |  |
| Baltimore  |  | Baltimore City Hospitals   |   |  |                                    | Carpenter  |   | Employed   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  | 13b. COUNTY                        |  | 13c. CITY OR TOWN                                 |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |  |   |  | Baltimore                          |  | Dundalk   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME  |  |  |   |  | 15. MOTHER'S MAIDEN NAME           |  |   |  |   |  |
| John H. Eckes  |  |  |   |  | Emma Kerns                         |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |   |  | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT ADDRESS                             |  |   |  |
| No   |  |  |   |  | 217-03-1189                        |  | George F. Eckes 1867 Marshall Rd. Balto. MD 21222 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |   |  |                                    |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |   |  |                                    |  |   |  |   |  |
| IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>   |  |  |   |  |                                    |  |   |  |   |  |
| 4275 DUE TO, OR AS A CONSEQUENCE OF (b) <u>UNKNOWN, ADVANCED AGE</u>   |  |  |   |  |                                    |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |   |  |                                    |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |  |   |  |                                    |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |  |   |  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |
|  |  |  | P.M. 19   |  |                                    |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION CITY OR TOWN COUNTY STATE  |   |  |   |  |
|  |  |  |   |  |                                    |  |   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>10/22</u> 19 <u>79</u> , to <u>11/6</u> 19 <u>79</u> , that (we) lost saw the deceased alive on <u>11/6/79</u> 19 <u>79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) |  |  |   |  |                                    |  |   |  |   |  |
| 22b. SIGNATURE   |  |  | DEGREE  |  |                                    | 22c. DATE SIGNED   |   |  |   |  |
| <u>Paul Richman MD</u>   |  |  |   |  |                                    | 11/6/79  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  |                                    |  |   |  |   |  |
| PAUL RICHMAN   |  |  | BALTO CITY HOSP. 7940 EASTERN AVE                                   |  |                                    |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE           |  |   |  |
| Burial   |  |  | 11/8/79   |  | Sacred Ht. of Jesus                |  | Baltimore, Baltimore, MD                          |  |   |  |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222  |  |  |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |   |  |
|  |  |  |   |  |                                    | NOV 7 1979   |   | <u>Henry H. Brady</u>  |   |  |

100-1-1

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535





BP

DHMH - 17  
(VR A105 ME (5))  
30M 7/73

|   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 22a Film 6531 REGISTRAR 1/21/80 re  |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 27302   |  |  |  |  |  |  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) alias.. Curtis   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTI. MATED 10 8 1979                                       |  |  |  |  |  |  |  |  |  | 2b. HOUR 10:14 a. M.  |  |  |  |  |  |  |  |  |  |
| 3. SEX male 4. RACE black 5. DATE OF BIRTH 11 12 20 6. AGE (IN YEARS) 58 7. DATE OF DEATH 11 10 19 79   |  |  |  |  |  |  |  |  |  | 8. MARRIED NEVER MARRIED WIDOWED DIVORCED   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 1007 West Lexington Street |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |  |  |  |  |  |  |
| 13a. STATE Md. 13b. COUNTY 13c. CITY OR TOWN Balto.   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES NO 13e. STREET ADDRESS 404 E. Biddle St.               |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 220-01-5141   |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 496- IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? YES XX NO  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                         |  |  |  |  |  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy XX Inspection Inquiry and in my opinion death resulted from Natural causes X Accident Suicide Homicide Undetermined manner                              |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE H. R. Guard  |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER                                     |  |  |  |  |  |  |  |  |  | DATE SIGNED 11/11/79  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.   |  |  |  |  |  |  |  |  |  | ADDRESS   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) Removal  |  |  |  |  |  |  |  |  |  | 23b. DATE 11/29/79  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME Anatomy Board   |  |  |  |  |  |  |  |  |  | ADDRESS Balto., Md.   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR DEC 3 1979  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| FOR<br>1- STATE<br>REGISTRAR   |  |         |  |                  |   |                   |  |                |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                          |  |  |  |  |          |  |  | REG. NO. 27303                       |  |  |  |  |
|--|--|---------|--|------------------|---|-------------------|--|----------------|--|--|--|--------------------------|--|--|--|--|----------|--|--|--------------------------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  |                  | FIRST MIDDLE LAST   |                   |  |                |  | 2a. DATE KNOWN OF DEATH  |  |                          |  |  | 2b. HOUR   |  |          |  |  |                                      |  |  |  |  |
| Mary Jane Edwards  |  |         |  |                  |   |                   |  |                |  | 2a. DATE KNOWN OF DEATH  |  |                          |  |  | 2b. HOUR   |  |          |  |  |                                      |  |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (IN YEARS) |  | IF UNDER 1 YR. |  | IF UNDER 24 HRS.   |  | 2c. DATE PRONOUNCED DEAD |  |  |  |  | 2d. HOUR |  |  |                                      |  |  |  |  |
| Female   |  | White   |  | 9 1 1958         |   | 21 YRS.           |  | MONTHS DAYS    |  | HOURS MIN  |  | 11 17 1979               |  |  |  |  | 11:26A   |  |  |                                      |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  |                  | 7b. CITIZEN OF WHAT COUNTRY?                                |                   |  |                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                          |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |          |  |  |                                      |  |  |  |  |
| Washington, DC   |  |         |  |                  | USA   |                   |  |                |  |  |  |                          |  |  | Baltimore City, MD.  |  |          |  |  |                                      |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                   |  |                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                          |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |  |  |                                      |  |  |  |  |
| Baltimore City   |  |         |  |                  | University Hospital   |                   |  |                |  | Photography  |  |                          |  |  | (same)   |  |          |  |  |                                      |  |  |  |  |
| 13a. STATE   |  |         |  |                  | 13b. CITY OR TOWN   |                   |  |                |  | 13d. INSIDE CITY LIMITS?   |  |                          |  |  | 13e. STREET ADDRESS  |  |          |  |  |                                      |  |  |  |  |
| Maryland   |  |         |  |                  | Howard  |                   |  |                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                          |  |  | 882A Town & Country Blvd.  |  |          |  |  |                                      |  |  |  |  |
| 14. FATHER'S NAME  |  |         |  |                  | 15. MOTHER'S MAIDEN NAME                                    |                   |  |                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |                          |  |  | 16b. SOCIAL SECURITY NO.   |  |          |  |  | 17. INFORMANT (husband) ADDRESS      |  |  |  |  |
| John F. Lawrence   |  |         |  |                  | Mary M. Hilleary  |                   |  |                |  | no   |  |                          |  |  | 217-70-6820  |  |          |  |  | John Rodney G. Edwards-(same as 13e) |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |                   |  |                |  |  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |                  | IMMEDIATE CAUSE (a):  |                   |  |                |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| 9551- Shotgun wound of head  |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |                  | (b):  |                   |  |                |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
|  |  |         |  |                  | (c):  |                   |  |                |  |  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   |  |                |  |  |  |                          |  |  | 20. AUTOPSY?   |  |          |  |  |                                      |  |  |  |  |
|  |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |          |  |  |                                      |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  |                  | 21b. TIME OF INJURY   |                   |  |                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
|  |  |         |  |                  | 10:40 PM 11/17/1979   |                   |  |                |  | Self inflicted   |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |         |  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   |  |                |  | 21f. LOCATION  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
|  |  |         |  |                  | home  |                   |  |                |  | 8820 A Town & Country Blvd. Ellicott City Md.  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:   |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |          |  |  |                                      |  |  |  |  |
| Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| ACTUAL SIGNATURE   |  |         |  |                  | TITLE (SPECIFY)   |                   |  |                |  | DATE SIGNED  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| Thomas D. Smith, M.D.  |  |         |  |                  | Deputy Chief  |                   |  |                |  | 11/18/79   |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  |                  | ADDRESS   |                   |  |                |  |  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| Thomas D. Smith, M.D.  |  |         |  |                  | 111 Penn St. Balto., MD                                     |                   |  |                |  |  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  |                  | 23b. DATE   |                   |  |                |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                          |  |  | 23d. LOCATION  |  |          |  |  |                                      |  |  |  |  |
| Burial   |  |         |  |                  | 11-20-79  |                   |  |                |  | Gate of Heaven   |  |                          |  |  | Sil. Spr. Montgomery Md.   |  |          |  |  |                                      |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  |                  | 25a. DATE REC'D. BY REGISTRAR                               |                   |  |                |  | 25b. REGISTRAR'S SIGNATURE   |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| Wahner E. Pumphrey, Inc.   |  |         |  |                  | NOV 23 1979   |                   |  |                |  | Lester McBrady   |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |
| 8434 Ga. Ave., S.S.  |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |  |  |  |          |  |  |                                      |  |  |  |  |



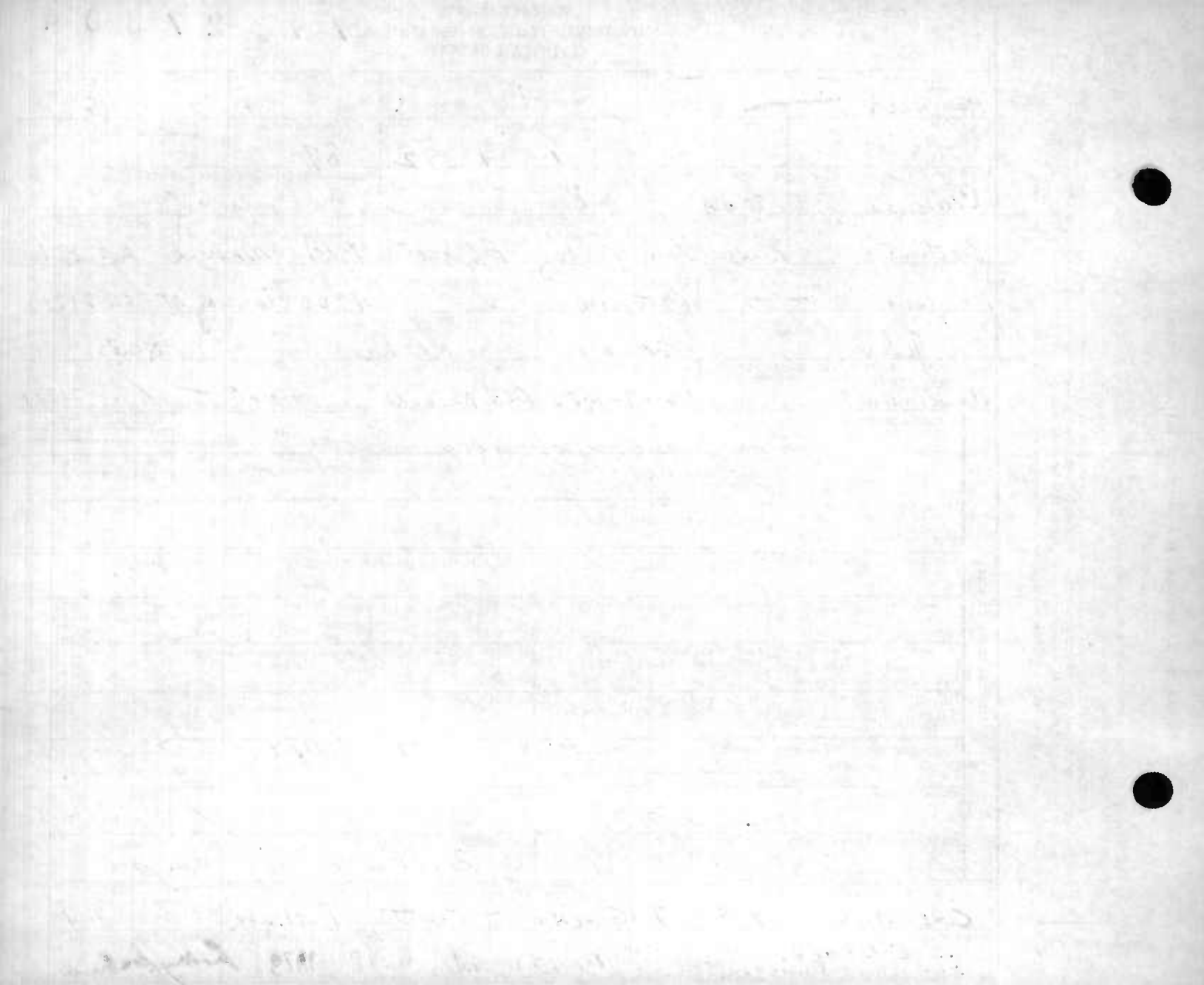


| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 7 9 2 7 3 0 4   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Reginald <del>Allen</del> Allan Edwards</u>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 11 4 79  |  |  |  |
| 3. SEX <u>Male</u>  |  | 4. RACE <u>White</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR 1 1 92  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>California</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.                               |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Harbor Land Building Bldg</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>MANAGER</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Apt Bldg</u>  |  |
| 13a. STATE <u>Maryland</u>  |  | 13b. COUNTY <u>Baltimore</u>  |  | 13c. CITY OR TOWN <u>Baltimore</u>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>Edwards</u> LAST <u>Edwards</u>   |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Rachel</u> MIDDLE <u>Ross</u> LAST <u>Ross</u>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. <u>116-67-9452</u>  |  |
| 17. INFORMANT <u>DCR Records</u>  |  | ADDRESS <u>4940 Eastern Ave. 21224</u>  |  | 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>4275<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> , 19 <u>77</u> , to <u>11/4</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>11/4</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE <u>D Siegel MD</u>   |  |   |  | DEGREE  |  | 22c. DATE SIGNED <u>11/4/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D Siegel</u>   |  |   |  | 22e. ADDRESS <u>Baltimore City Hosp</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>  |  | 23b. DATE <u>11-8-79</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CREMATORY</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore</u> MD.                                 |  |
| 24. FUNERAL DIRECTOR NAME <u>E BARNES</u> ADDRESS <u>FLEMING FUNERAL SERVICE BENSON, MD</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <u>NOV 8 1979</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Ruthy K. K...</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |   |   |   |  |
|---|--|---|---|--|---|---|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>ARTHUR C. EHRHART</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 26 79</b>                 |  |   | 2b HOUR<br><b>7:15 PM</b>   |   |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 23, 1912</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>   |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Personal Officer for S.S.A.</b>   |   | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>Baltimore</b>  |   | 13c CITY OR TOWN<br><b>RANDALLSTOWN</b>  |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e STREET ADDRESS<br><b>21133 3720 LA MOINE RD</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Ehrhart</b>   |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mae Rheer</b>   |   |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |   |   | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 11</b>  |   | 17 INFORMANT<br><b>Mr. Ronald E. Ehrhart</b>  |   |   |  |
|   |  |   |   | <b>216-28-7088</b>   |   | <b>3720 La Moine Rd. Randallstown, MD. 21133</b>  |   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRAIN STEM INFARCTION</b><br><b>4349</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>GENERALIZED ARTERIO-SCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 WEEKS</b><br><b>30 YEARS</b> |  |   |   |  |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>SEPSIS; CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>  |  |   |   |  |   |   |   |   |  |
| 19a DATE OF OPERATION<br><b>11/26</b>   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>10/24</b> , 19 <b>79</b> , to <b>11/26</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death.   |  |   |   |  |   |   |   |   |  |
| 22b SIGNATURE<br><b>William S. Wood</b>   |  |   | DEGREE<br><b>MD</b>   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c DATE SIGNED   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM S WOOD, MD</b>   |  |   | 22e ADDRESS<br><b>SINAI HOSPITAL OF BALTIMORE</b>                     |  |   |   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b DATE<br><b>11/30/79</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b> |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balto. MD.</b> |   |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, P.A.<br/>8728 Liberty Road Randallstown, MD. 21133</b>  |  |   |   |  |   | 25 DATE REC'D. BY REGISTRAR<br><b>NOV 29 1979</b>   |   | 25b REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |  |

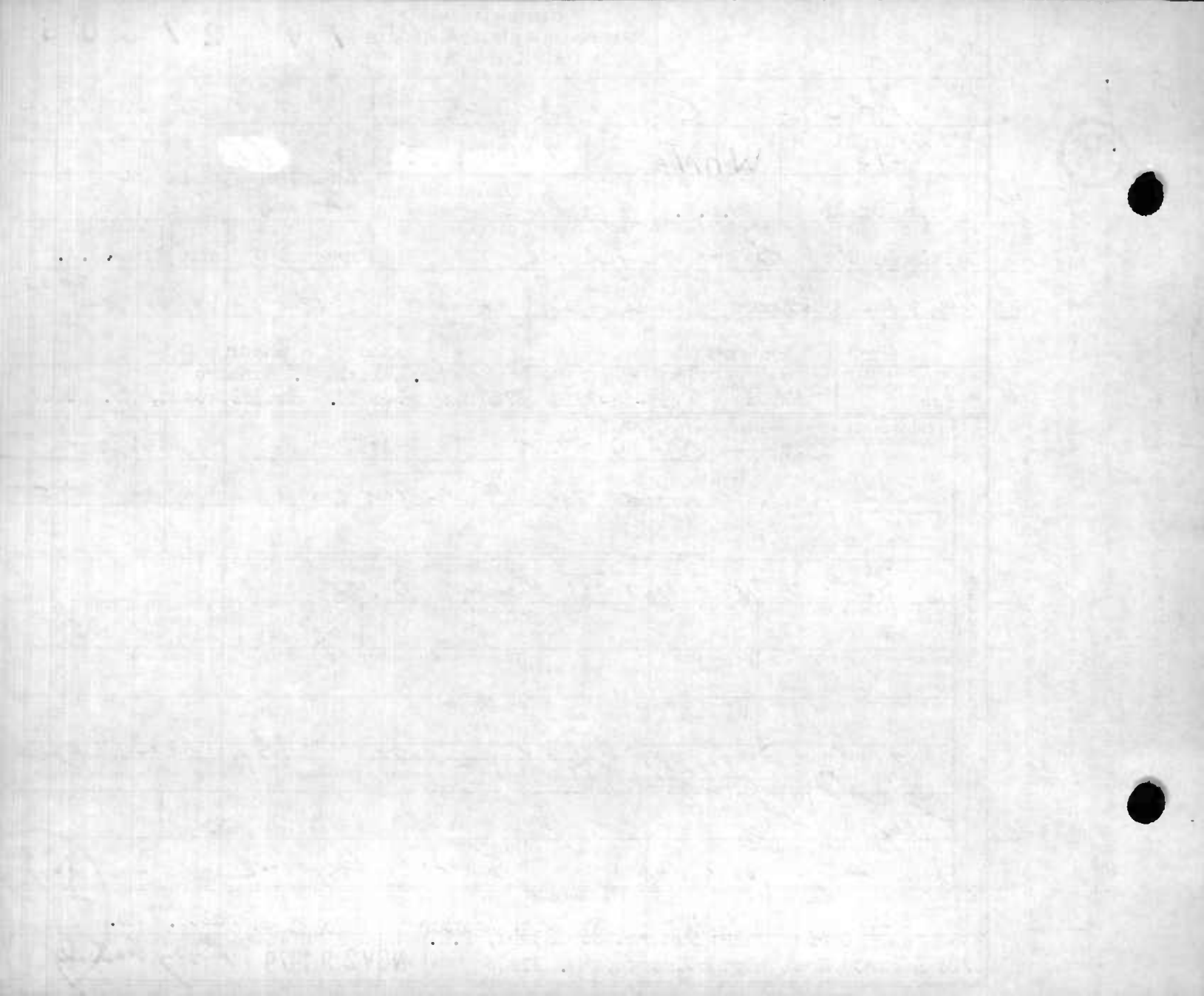
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |                                      |  |   |  |  |  |
|---|--|--|--|--|--------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HILDA NMI EINOLF</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-4-79</b>                  |  |                                      | 2b. HOUR<br><b>11:10A</b>  |   |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Caus</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-22-11</b>  |                                      | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(DO NOT INscribe AND GIVE LIFE ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |  |                                      | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |   | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>   |  |  | 13b COUNTY<br><b>---</b>   |  | 13c CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3709 Coolidge Ave. 21229</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN HARDINGHAM</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NELLIE UNKNOWN</b> |  |                                      |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | (IF YES, GIVE WAR OR DATES)  |  | 16b SOCIAL SECURITY NO.<br><b>215-03-6965</b>  |                                      | 17. INFORMANT<br>ADDRESS<br><b>Betty Ridgell 1911 Hillcrest Road</b>   |   |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Decompensated congestive heart failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |  |  |  |                                      |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |  |                                      |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                      |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                      |  |   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>11-2</b> , 19 <b>79</b> , to <b>11-4</b> , 19 <b>79</b> , that (1) <input checked="" type="checkbox"/> I lost<br>saw the deceased alive on <b>11-4</b> , 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above, (b) <input type="checkbox"/> I did not view the body after death. |  |  |  |  |                                      |  |   |  |  |  |
| 22b. SIGNATURE<br><b>DO - HSLG Hung</b>   |  |  |  |  |                                      | DEGREE<br><b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11-4-79</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HUNG</b>  |  |  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALTIMORE, MD. 21229</b>   |                                      |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/7/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Maus</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balto. Md.</b>   |   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home</b>  |  |  |  | ADDRESS<br><b>4107 Wilkens Ave.</b>  |                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. Kelly</b>   |  |  |

CHICAGO CITY

BALTIMORE BY AIR MAIL

815

200 EASTON AVE., BALTIMORE, MD. 21202

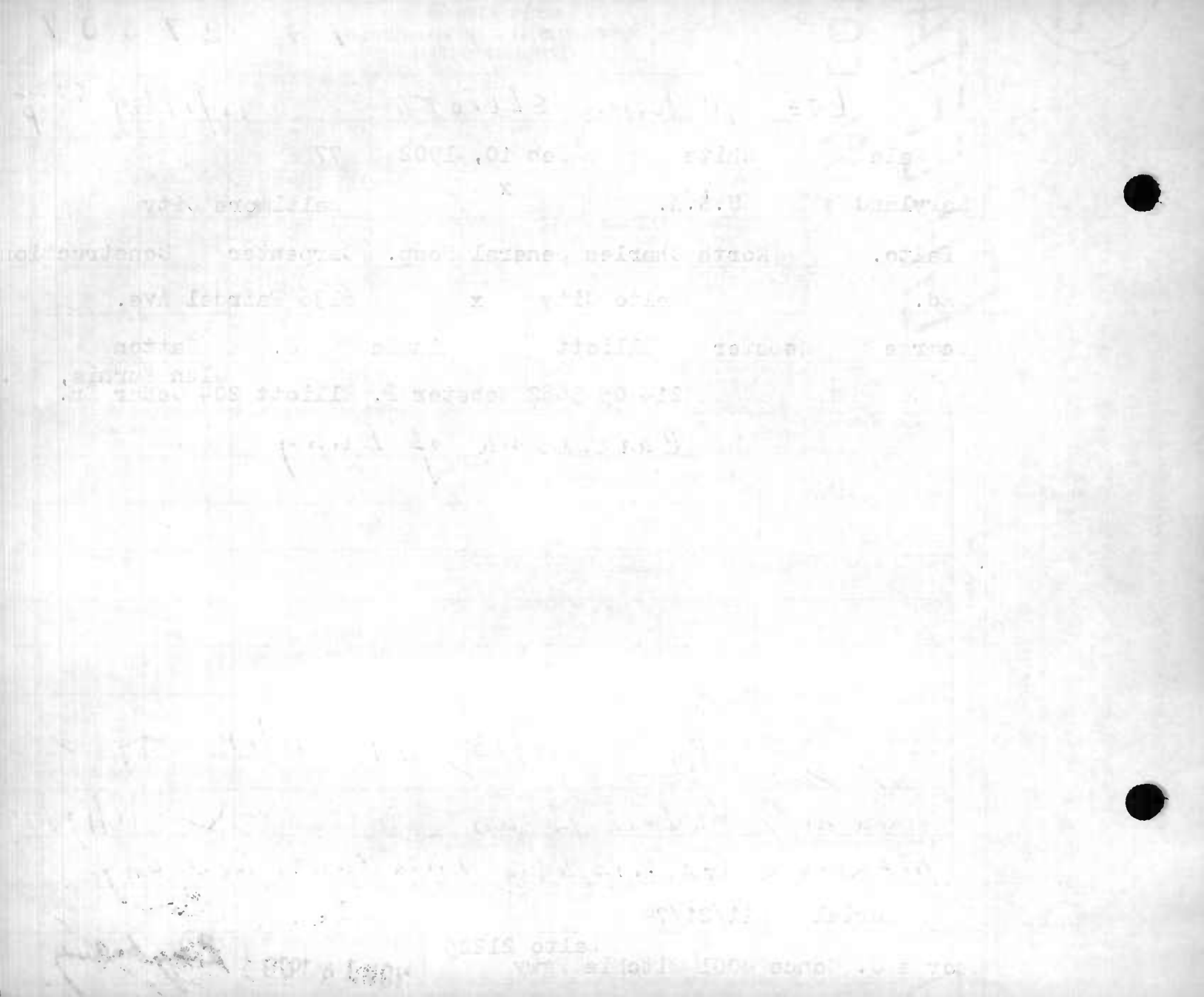


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

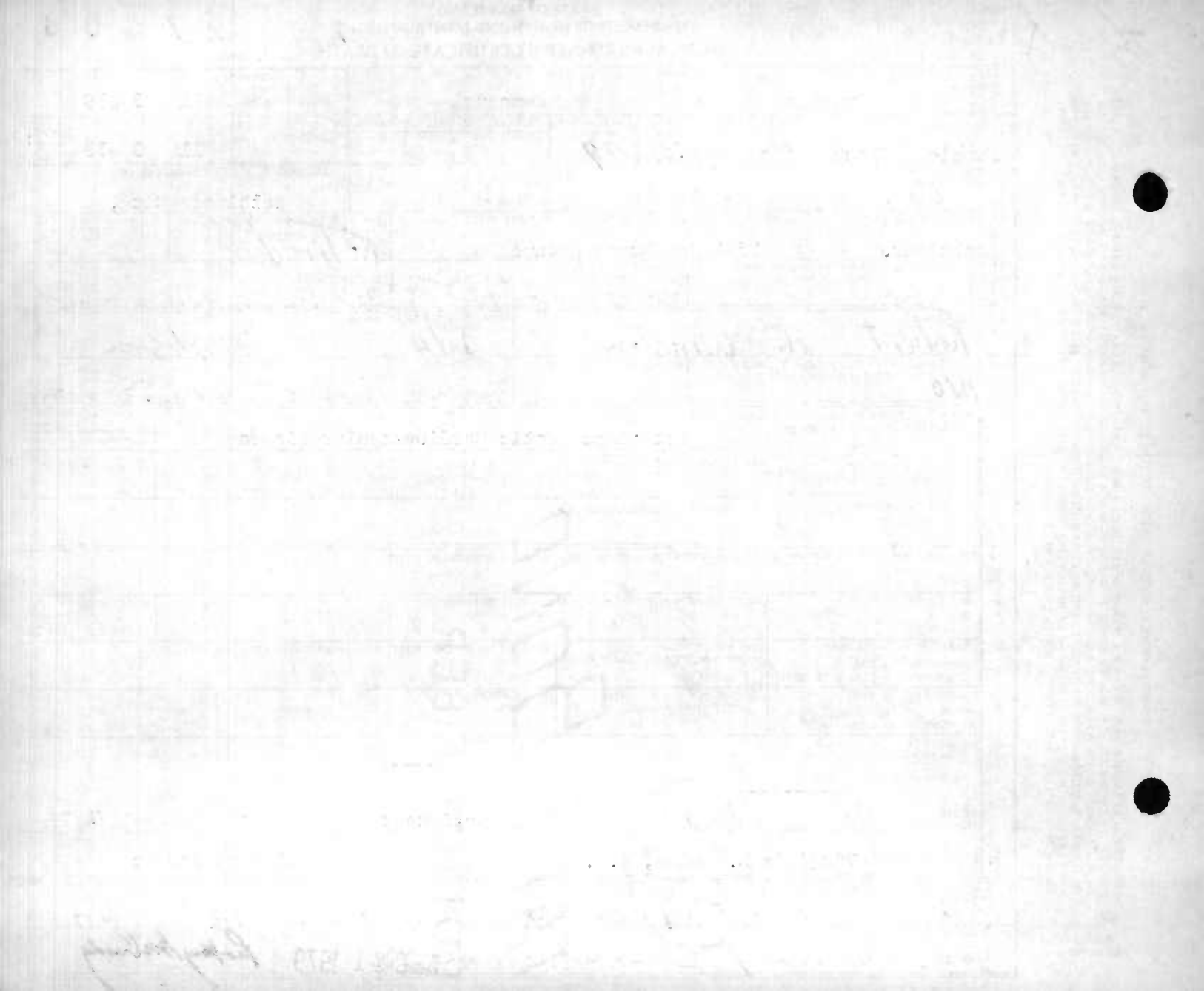
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 27307   |   |  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST<br>LEE MELVIN ELLIOTT |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>11/17/79   |  | 2b HOUR<br>6:26 PM   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb 10, 1902  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>77   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Charles General Hosp. |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Construction   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.   |  | 13b COUNTY<br>Balto City   |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13c STREET ADDRESS<br>6136 Fairdel Ave.  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Webster Elliott   |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie J. Gatton   |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>214 05 3682   |   | 17. INFORMANT<br>ADDRESS<br>Glen Burnie, Md.<br>Webster F. Elliott 204 Cedar Dr.   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>} DUE TO, OR AS A CONSEQUENCE OF (b)<br>} DUE TO, OR AS A CONSEQUENCE OF (c)         |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |   |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> 19 <u>79</u> , to <u>11/17</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Marcos B. Galicia Jr.</u>  |  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/17/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARCOB B. GALICIA JR. MD   |  |  |   | 22e. ADDRESS<br>North Charles Gen. Hosp.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/21/79  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce 4001 Ritchie Hgwy   |  |  |   | ADDRESS<br>Balto 21225   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ruby M. G...</u>  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |   |  |   |  |  |  | REG. NO. 27308           |  |
|---|---------|--|--|---|--|---|--|--|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH                      |  | 2b. HOUR                 |  |
| Onzella   |         |  |  |   |  | Emmanuel  |  | X MONTH DAY YEAR<br>11 3 19 79               |  | M<br>10:08 A M           |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                             |  | 2c. DATE PRONOUNCED DEAD |  |
| Female  | Black   | Nov. 11, 1901  |  | 77 YRS.   |  |   |  |  |  | 11 3 19 79               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |                          |  |
| Va.   |         | U.S.A.   |  | WIDOWED   |  | DIVORCED  |  | Baltimore City,                              |  | MD.                      |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                          |  |
| Baltimore   |         | 2504 Woodbrook Avenue  |  | Retired   |  |   |  |  |  |                          |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |                          |  |
| MARYLAND  |         |  |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2504 WOODBROOK AVE                           |  |                          |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                                |  | ADDRESS                  |  |
| Robert T. H. Winston  |         | Ida Madison  |  | NO  |  |   |  | Mr Robert Winston                            |  | 2504 WOODBROOK AVE       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | Arteriosclerotic Cardiovascular Disease                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |
| 4292  |         |  |  |   |  |   |  |  |  |                          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |         |  |  |   |  |   |  |  |  |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |  |   |  |  |  |                          |  |
| (b)   |         |  |  |   |  |   |  |  |  |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |  |   |  |  |  |                          |  |
| (c)   |         |  |  |   |  |   |  |  |  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |   |  |   |  |  |  |                          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |  |  |                          |  |
|   |         |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |   |  |  |  |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |                          |  |
|   |         | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  |   |  |  |  |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY                                       |  | STATE                    |  |
|   |         |  |  |   |  |   |  |  |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)   |  | DATE SIGNED   |  |  |  |                          |  |
| ACTUAL SIGNATURE  |         | Virginia L. Dolan, M.D.  |  | M.D. Assistant  |  | MEDICAL EXAMINER  |  | 11/4/79                                      |  |                          |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | Virginia L. Dolan, M.D.  |  | ADDRESS   |  | 111 Penn Street   |  |  |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (CITY OR TOWN)  |  | COUNTY                                       |  | STATE                    |  |
| BURIAL  |         | 11-8-79  |  | 1ST BAPT CHURCH CEM   |  | CHURCHES  |  | VA   |  |                          |  |
| 24. FUNERAL DIRECTOR NAME   |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |                          |  |
| Joseph C. Burns   |         | 2222 W. North Ave  |  | DEC 21 1979   |  |   |  |  |  |                          |  |



RELEASED BY MEDICAL EXAMINER'S OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |   |   |                                 |  |
|--|--|---|--|--|---|---|---|---------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |   |   |   |                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Edward MIDDLE LAST Enders   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 11 21 79   |   |   |                                 |  |
| 3. SEX Male  |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR 11 9 1917  |   | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.                                   |   | 2b. HOUR 6:32 P.M.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                   |   |                                 |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Water Dept. |   | 12b. KNOWN BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore   |  |   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13c. STREET ADDRESS 305 S. Conkling Street  |                                 |  |
| 14. FATHER'S NAME FIRST Frank MIDDLE LAST Enders   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST Carrie MIDDLE LAST Glock   |   |   |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes  |  | 16b. SOCIAL SECURITY NO. WW II 220-01-0900  |  | 17. INFORMANT Frank Enders   |   |   | ADDRESS 45 Wise Avenue Balto. MD 21222  |                                 |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>3489 DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe brain damage</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |  |  |   |   |   |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |                                 |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |   |                                 |  |
| 22a. I certify that (1) this hospital attended the deceased from Nov 18 19 79, to Nov 21 19 79, that (1) (we) lost saw the deceased alive on Nov 21 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.   |  |   |  |  |   |   |   |                                 |  |
| 22b. SIGNATURE Sandra M. Walden M.D.   |  |   |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED 11/21/79   |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANDRA M. WALDEN, MD   |  |   |  |  | 22e. ADDRESS BCH  |   |   |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 11/26/79  |  | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery   |   | 23d. LOCATION CITY OR TOWN Baltimore, Balto. MD                           |   | STATE                           |  |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR NOV 28 1979   |   | 25b. REGISTRAR'S SIGNATURE [Signature]  |                                 |  |

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

NOTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Bessie   |  | M.   |  | Engel  |  |  |  | November 22, 1979   |  | 4:50 A                                       |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 7b. IF UNDER 24 HRS HOURS MIN                |  |
| Female   |  | White  |  | 5 26 87  |  | 92 YRS   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Baltimore Md.  |  | U.S.A.   |  |  |  | Baltimore City MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |   |  |  |  |
| Baltimore  |  | Pleasant Manor N. H.   |  |  |  |  |  |   |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |   |  |  |  |
| Housewife  |  | Home   |  |  |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |  |  |
| Md.  |  | Balto.   |  | Baltimore  |  |  |  | 32 Lyndale Avenue   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |   |  |  |  |
| William  |  | Hamack   |  | Amelia   |  | Tames  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |  |  |
| N8   |  | 215-01-3331  |  | Pleasant Manor Nursing Center<br>4615 Park Heights Avenue 21215  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Severe atherosclerotic cardiovascular</u>  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dissect</u>   |  |  |  |  |  |  |  |   |  | 2 yrs.                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
|  |  |  |  |  |  |  |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>77</u> , to <u>11-22</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11-22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |  |  |  | 22c. DATE SIGNED  |  |  |  |
| Jaime Punzalan   |  |  |  |  |  |  |  | 11-22-79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |  |
| Jamie M. Punzalan, M. D.   |  | 5214 Harford Road, 21206   |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial   |  | 11/26/79   |  | Baltimore Cemetery   |  | Baltimore, Maryland  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| Schimunek Funeral Home, Inc.   |  | 331 Brehms Lane, Balto. Md.  |  | NOV 27 1979  |  | [Signature]  |  |   |  |  |  |

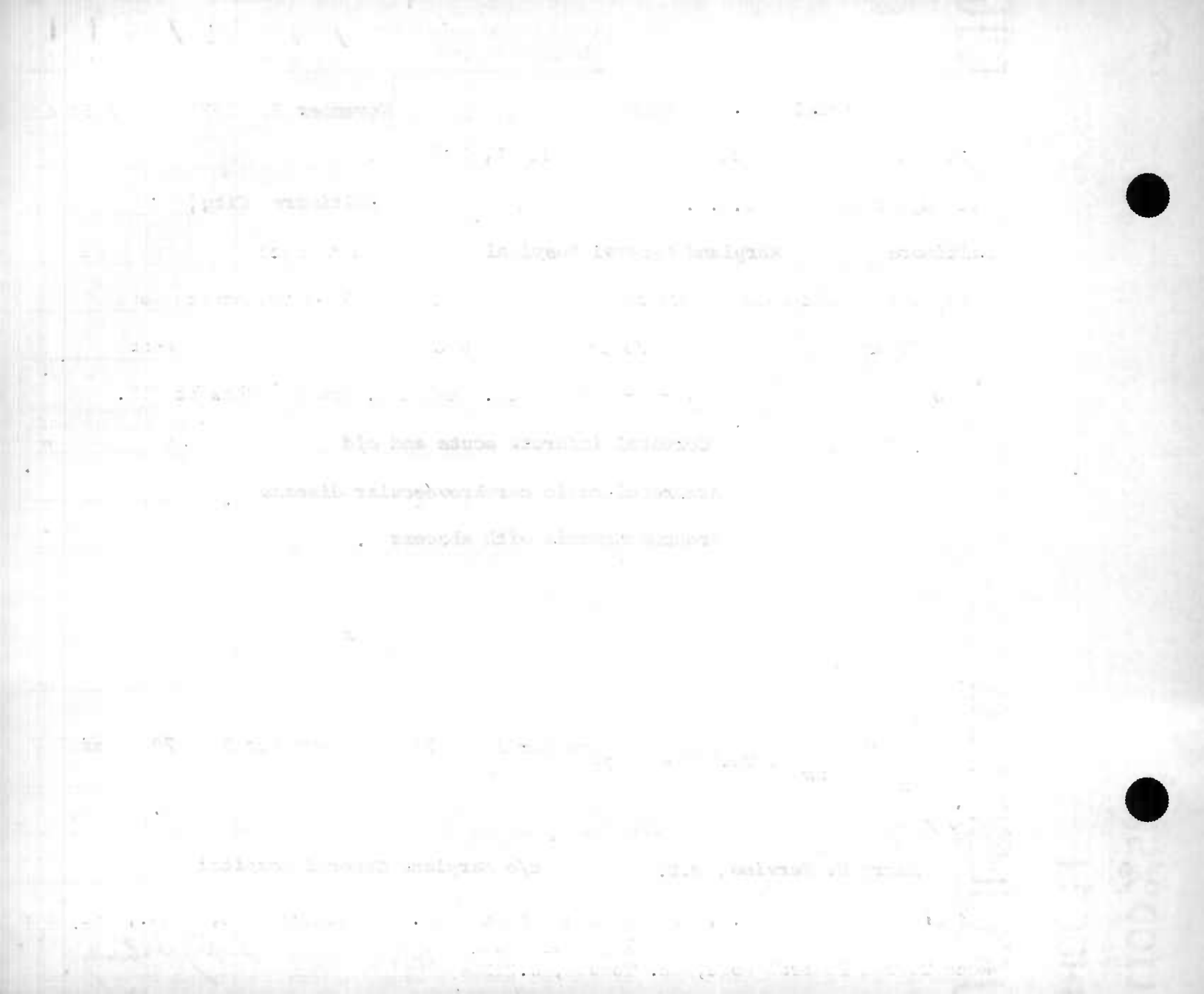




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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 2 7 3 1 1  |  |  |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Hazel C. Esch  |  |  |  |  |  |  |  | November 3, 1979  |  | 8:50 a M                                     |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 IF UNDER 1 YEAR MONTHS DAYS   |  | 8 IF UNDER 24 HRS HOURS MIN.                 |  |
| Female   |  | White  |  | August 22, 1901  |  | 78 YRS   |  |   |  |  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 9b. CITIZEN OF WHAT COUNTRY?   |  | 10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Pennsylvania   |  | U.S.A.   |  |  |  | Baltimore City, MD.  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                              |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore  |  | Maryland General Hospital  |  |  |  | Home Maker   |  | Own Home  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 14 INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 15 STREET ADDRESS   |  |  |  |
| Maryland   |  | Baltimore  |  | Towson   |  |  |  | 1004 Breezewick Road  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  |  |   |  |  |  |
| Kirker   |  | Jones  |  | Mabel  |  | Hannah   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO  |  | 17 INFORMANT ADDRESS   |  |  |  |   |  |  |  |
| No   |  | 070-10-5112 D  |  | Mrs. Nellie B. Brady Same as #13.  |  |  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral infarcts acute and old</u>   |  |  |  |  |  |  |  |   |  |  |  |
| 4349 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic cerebrovascular disease</u>   |  |  |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchopneumonia with abscess</u>   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <u>November 1</u> , 19 <u>79</u> , to <u>November 3</u> , 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>November 2</u> , 19 <u>79</u> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22a. SIGNATURE   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |
| <u>Harry E. Nervino, M.D.</u>  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |  |  | 11/3/79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| Harry E. Nervino, M.D.   |  |  |  | c/o Maryland General Hospital  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial   |  | Nov. 6, 1979   |  | Dulaney Valley Cem.  |  | Cockeysville, Balto., Maryland   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| Ruck Towson Funeral Home, Inc.   |  | 1050 York Road   |  | NOV 6 1979   |  | <u>Harry E. Nervino</u>  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   | 7 9 2 7 3 1 2                         |  |   |  |
|---|--|--|--|---|---------------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.                              |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Effie Rae Eszto</i>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Nov. 27, 1979</i>                       |   | 2b. HOUR<br>M                         |  |   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>May 23, 1925</i>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>54</i> YRS.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>W. Virginia</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1325 Webster St. Balto. Md.</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>   |                                       | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>William ----- Helmick</i>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Unknown</i>                   |   |                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |   |  |
| 16b. SOCIAL SECURITY NO.<br><i>579-30-3479</i>  |  |  | 17. INFORMANT ADDRESS<br><i>Mrs. Roger Lee Moore, 2845 Maudlin Ave. Balto.</i> |   |                                       | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Atherosclerosis with</i><br><i>436-</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Possible Stroke -</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Was Found Dead</i> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |                                       |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><i>Citien Burme</i>  |                                       |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1976</i> 19, to <i>11/27</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>Sept</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death. |  |  |  | 22b. SIGNATURE<br><i>[Signature]</i>  |                                       | 22c. DATE SIGNED<br><i>11/28/79</i>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DR SAWHUN BY</i>  |  |  |  | 22e. ADDRESS<br><i>205 Balto - Annapolis Blvd</i>   |                                       |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>Dec. 1, 1979</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Mem. Park</i>  |                                       | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Howard Co. Maryland</i>  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 30 1979</i>   |                                       | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |  |



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1. FOR  
STATE  
REGISTRAR

REG. NO.

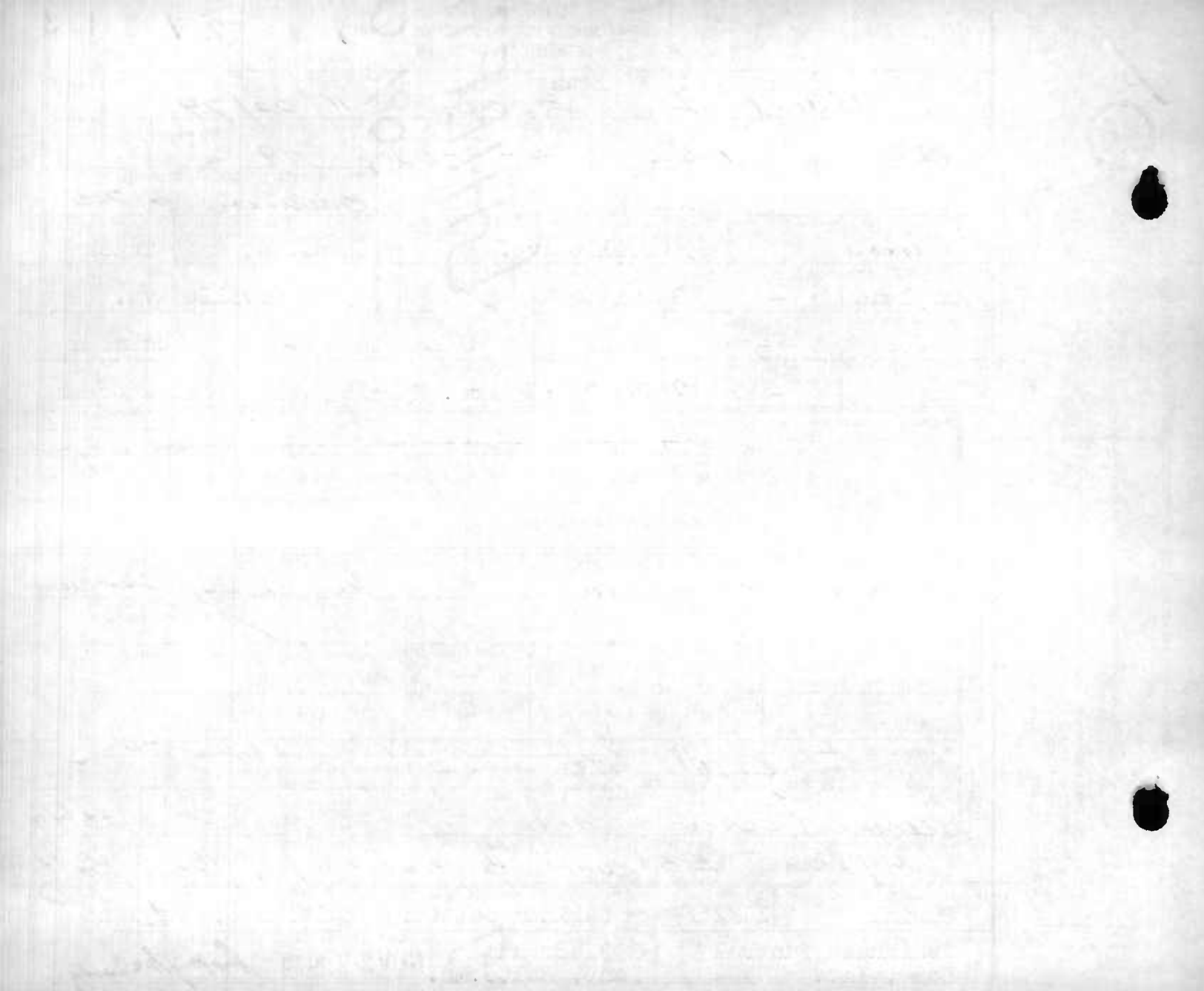
|   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Albert L. Evans</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/23/79</b>  |  |   |  | 2b. HOUR<br><b>M</b>  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4-3-00</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS                                     |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> <b>21205</b> MD             |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5085 Orville Ave.</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chauffeur</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Truck</b>  |  |
| 13a STATE<br><b>Maryland</b>  |  |   |  | 13b COUNTY<br><b>-</b>   |  | 13c CITY OR TOWN<br><b>Baltimore</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e STREET ADDRESS<br><b>5085 Orville Ave.</b>  |  |   |  |  |  |   |  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Joseph - Evans</b>   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth - Unknown</b>  |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |  | 16b SOCIAL SECURITY NO<br><b>212105848</b>   |  | 17 INFORMANT ADDRESS<br><b>Mrs. Myrhle Evans same address</b>                       |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer soft Palate</b><br><b>1453</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(Squamous Ca)</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Severe Chronic Obstructive Pulmonary Disease</b>   |  |   |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a I certify that (I) (we) hospital attended the deceased from <b>8/16</b> 19 <b>79</b> to <b>8/16</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8/16</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |   |  |  |  |   |  |   |  |
| 22b SIGNATURE<br><b>Myrna T. Estrach MD</b>   |  |   |  | DEGREE<br><b>MD</b>  |  |   |  | 22c DATE SIGNED<br><b>11/23/79</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MYRNA T. ESTRACH</b>   |  |   |  | 22e ADDRESS<br><b>Baltimore City Hosp. Balt.</b>   |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>11/26/79</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b>   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |  |   |  |
| 24 FUNERAL DIRECTOR<br><b>Sanimunek Funeral Home, Inc.</b>  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>NOV 27 1979</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b>                                 |  |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 7 9 2 7 3 1 4   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br><b>Gertrude Evans</b>  |  |   |  | MONTH DAY YEAR<br><b>11 4 79</b>  |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| F   |  | B   |  | MONTH DAY YEAR<br><b>6 1 94</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| N.C.  |  | USA   |  |   |  | Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Balto.  |  | 2111 Rupp St.   |  |   |  |  |  |
| 13a. STATE  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| Md  |  |   |  |   |  | Balto.   |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| FIRST MIDDLE LAST   |  |   |  | FIRST MIDDLE LAST   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |
| No  |  |   |  | 212-18-9614   |  | Flora Evans 2111 Rupp St.                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular dis.</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u></u> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>years</u>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                               |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Salvatore</u> MD   |  |   |  | DEGREE  |  | 22c. DATE SIGNED<br><u>11/2/79</u>                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JOSEPH R. SALVATORE MD</u>  |  |   |  | 22e. ADDRESS<br><u>Maryland General Hosp</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |
| Burial  |  | 11/9/79   |  | Md. Nat. Mem. Pk.   |  | Laurel, Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  |
| Wm C March F/H  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Johny Salandy</u>  |  |  |  |
| ADDRESS   |  |   |  | 25c. DATE REC'D. BY REGISTRAR   |  |  |  |
| 1101 E. North Ave.  |  |   |  | NDV 7 1979  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| Item #5 per phone call w/Fun. Home   |                              |  |  | STATE OF MARYLAND  |  |   |  |
|--|------------------------------|--|--|--|--|---|--|
| FOR 1 - STATE REGISTRAR  |                              |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |
| 11/7/79 rc   |                              |  |  | 7 9 2 7 3 1 5  |  |   |  |
| CERTIFICATE OF DEATH   |                              |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |                              | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  |
| JOHN   |                              | EVANS  |  | 11 17 79   |  | 2:55 P.M.   |  |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  |
| male   | white                        | MONTH DAY YEAR   |  | 7 31 79  |  | MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| MD   | U.S.A.                       |  |  | City Baltimore MD.   |  |   |  |
| 11. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore Md.  |                              | University Hospital  |  | mechanic   |  | industrial  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Md.  |                              | Anne Arundel   |  | Linthicum  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |                              | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS  |  |   |  |
| FIRST MIDDLE LAST  |                              | FIRST MIDDLE LAST  |  | 22 S. Greene St. Hatfield  |  |   |  |
| Aaron  |                              | Evans  |  | 22 S. Greene St. Hatfield  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |
| no   |                              | 2209 8485  |  | Ruth M. Evans 21 Rosedale Avenue 21061   |  |   |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                              |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure  |                              |  |  |  |  |   |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Cat cell Ca. of lung   |                              |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |                              |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |                              |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |                              |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |                              |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|  |                              | P.M. 19  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|  |                              |  |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 19 19 79, to Nov 1 19 79, that (I) (we) last saw the deceased alive on Nov 1 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |  |  |  |  |   |  |
| 22b. SIGNATURE   |                              | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| STEPHEN A. VALENTI   |                              | MD   |  |  |  | 11/1/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                              | 22e. ADDRESS   |  |  |  |   |  |
| STEPHEN A. VALENTI   |                              | 22 S. Greene St. Baltimore Md.   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| Burial   |                              | 11/5/79  |  | Glen Haven Cemetery  |  | Glen Burnie Anne Arundel  |  |
| 24. FUNERAL DIRECTOR NAME  |                              | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Ambrose Funeral Home   |                              | 1328 Sulphur Spring Rd.  |  | NOV 2 1979   |  | Ruth M. Evans   |  |

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Postmortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove transportation. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 3 1 6

REG. NO.

|   |  |   |   |   |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Howard L. Everett</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>11-12-79</b> |   |  | 2b. HOUR<br><b>7:15 P.M.</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10-22-16</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. of Maryland</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Balto. City</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>916 N. Carey St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>(Ethel) Wyatt Everett</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estelle EVERETT (Estelle)</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>unknown</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>224-14-8029</b>  |   | 17. INFORMANT<br><b>Dorothy Everett</b>   |  | ADDRESS<br><b>same</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Intractable Sepsis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>Nov. 12</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov. 12</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                                   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Albert F. Deloskey MD</b>  |  |   |   | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/12/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Albert F. Deloskey</b>  |  |   |   | 22e. ADDRESS<br><b>University Hospital</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/19/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 East North Avenue</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                   |  |
|---|--|--|--|--|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 7 9 2 7 3 1 7  |   |  |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH  |   |  |                                   |  |
| LOUISE FALAHEE  |  |  |  |  | 11 13 79 1 30 AM   |   |  |                                   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  | 7. IF UNDER 1 YEAR                |  |
| FEMALE  |  | CAUCASIAN  |  | 3 5 02   |  | 77 YRS  |  | MONTHS DAYS HOURS MIN             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |  |
| UNK   |  | USA  |  |  |  | BALTO. CITY MD.   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore   |  | UNIVERSITY HOSPITAL  |  |  |  | UNK   |  |                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  | 13b. INSIDE CITY LIMITS?   |   |  |                                   |  |
| 13a. STATE  |  |  |  |  | 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |                                   |  |
| 13a. MD   |  | 13b. Carroll   |  | 13c. CITY OR TOWN  |  | 13c. STREET ADDRESS   |  |                                   |  |
|   |  | Sykesville   |  |  |  | Springfield State Hosp  |  |                                   |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |  |
| 14. FIRST MIDDLE LAST   |  |  |  |  | 15. FIRST MIDDLE LAST  |   |  |                                   |  |
| NA. late Frederick Leiss  |  |  |  |  | NA. late Catherine   |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO  |   |  |                                   |  |
|   |  |  |  |  | 218 18 NA. 3346 T  |   |  |                                   |  |
| 17. INFORMANT   |  |  |  |  | ADDRESS  |   |  |                                   |  |
|   |  |  |  |  | Mrs Anna Michaelis 295 Riverside Dr Pasadena                             |   |  |                                   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |                                   | 10 min                                       |
| IMMEDIATE CAUSE (a)   |  |  |  |  |  |   |  |                                   |  |
| 1820 Cardiac arrest   |  |  |  |  |  |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |                                   | 4 week                                       |
| (b) Small Bowel Obstruction   |  |  |  |  |  |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |                                   | 1 1/2 yrs                                    |
| (c) Metastatic Carcinoma of Endometrium   |  |  |  |  |  |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |                                   |  |
| None  |  |  |  |  |  |   |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
| None  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                                   |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |                                   |  |
|   |  | P.M. 19  |  |  |  |   |  |                                   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |                                   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/21, 1979 to 11/13, 1979, that (1) (we) lost   |  |  |  |  |  |   |  |                                   |  |
| saw the deceased alive on 11/13, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                   |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |  |
| Nelson N Stone MD   |  |  |  |  | MD   |   | 11/13/79   |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  | 22e. ADDRESS   |   |  |                                   |  |
| Nelson N Stone MD   |  |  |  |  | University Hospital  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |                                   |  |
| Burial  |  | Nov 15 '79   |  | Westview   |  | Catonville Maryland STATE                                     |  |                                   |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. DATE REC'D BY   |   | 25b. REGISTER'S SIGNATURE                                      |                                   |  |
| Harry H. Witzke 4112 Columbia Rd Ellicott City  |  |  |  |  | NOV 15 1979  |   | [Signature]  |                                   |  |

BP



RECEIVED

NOV 19 1954

U.S. AIR FORCE

WASHINGTON

OFFICE OF THE SECRETARY OF THE AIR FORCE

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 3 1 8

|  |  |  |  |  |  |  |  |                                    |  |  |  |
|--|--|--|--|--|--|--|--|------------------------------------|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH  |  | DAY  |  | YEAR                               |  | 2b. HOUR                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 11                                 |  | 12:47 A M                                    |  |
| CARMEN   |  | FALLANO  |  |  |  |  |  |                                    |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | IF UNDER 1 YEAR                    |  | IF UNDER 24 HRS                              |  |
| male   |  | white  |  | MONTH DAY YEAR   |  | 82 YRS   |  | MONTHS DAYS                        |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | BALTIMORE CITY OR COUNTY OF DEATH                              |  |                                    |  |  |  |
| BALT. MO.  |  | US   |  |  |  | Baltimore City   |  |                                    |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                                    |  |  |  |
| BALT. Md.  |  | MERCY Hosp   |  | Tavern owner   |  |  |  |                                    |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. STATE   |  | 13c. COUNTY  |  | 13d. CITY OR TOWN  |  | 13e. STREET ADDRESS                |  |  |  |
| md   |  |  |  |  |  | BALT   |  | 3014 Oakcrest Ave                  |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                                    |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |  |  |                                    |  |  |  |
| Jerry (Gennaro) Fallano  |  | MARY   |  |  |  |  |  |                                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |                                    |  |  |  |
| Yes  |  | WWI  |  | 218-01-7530  |  | Anthony Fallano  |  | same                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  | PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)                             |  | DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4413   |  | cardiac arrest   |  | ruptured abdominal aortic aneurysm   |  | Immediate  |  |                                    |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  | cerebral vascular accident   |  |  |  |  |  |                                    |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                    |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |                                    |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |                                    |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN   |  | COUNTY                             |  | STATE  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET   |  |  |  |                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-16 19 79, to 11-3 19 79, that (I) (we) last saw the deceased alive on 11-3 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |                                    |  |  |  |
|  |  | STUART L. JACOBS MD  |  |  |  | 11-3-79  |  |                                    |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |                                    |  |  |  |
| STUART L. JACOBS MD  |  | Mercy Hosp. 301 St. Paul Pl.   |  |  |  |  |  |                                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | CITY OR TOWN                       |  | COUNTY STATE                                 |  |
| Burial   |  | 6 Nov 79   |  | Holy Redeemer Cemtry,  |  | Baltimore, Md.   |  |                                    |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                                    |  |  |  |
| Schmunek Funeral Home, Inc.  |  | NOV 7 1979   |  | Anthony Fallano  |  |  |  |                                    |  |  |  |
| 3331 Brehms Lane Baltimore, Md.  |  |  |  |  |  |  |  |                                    |  |  |  |

2735

1975 1004

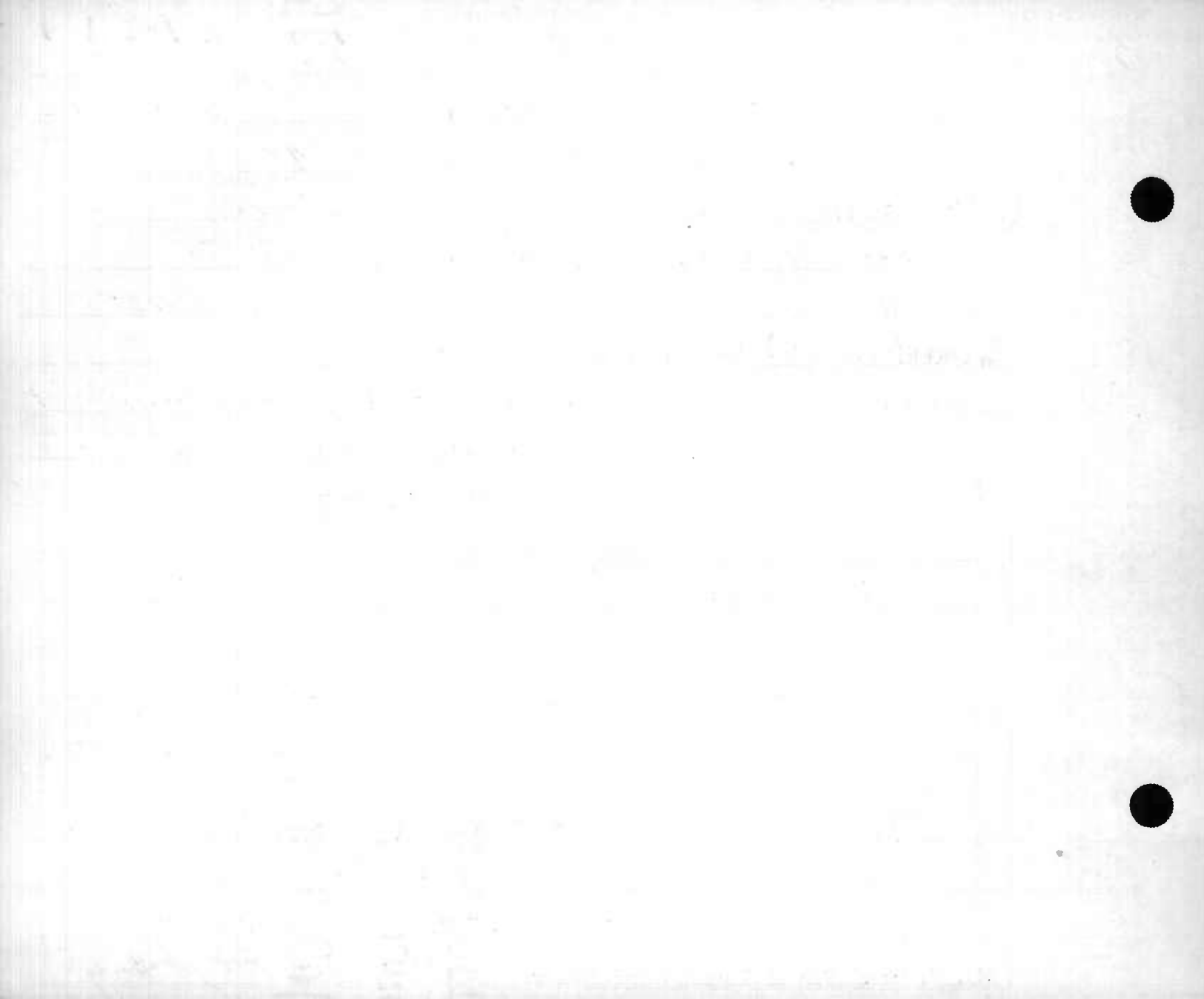


TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | 7 9 2 7 3 1 9<br>REG. NO.  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>Spencer   |  |  | MIDDLE<br>Fauntleroy   |  |  | LAST<br>Fauntleroy   |  |  |
| 2a. DATE OF DEATH   |  |  | MONTH<br>11  |  |  | DAY<br>25  |  |  | YEAR<br>79   |  |  |
| 2b. HOUR<br>9:45 AM   |  |  | 3. SEX<br>MALE   |  |  | 4. RACE<br>BLACK   |  |  | 5. DATE OF BIRTH   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.  |  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland, VA.  |  |  | 8. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Federal Hill Nursing Center |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNKNOWN    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br>Baltimore   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST<br>Spencer (unknown)   |  |  | MIDDLE<br>(unknown)  |  |  | LAST<br>Fauntleroy   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>(unknown)   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNKNOWN   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-26-0045   |  |  | 17. INFORMANT<br>MARIE Fauntleroy  |  |  | ADDRESS<br>244 N. Spring Ct  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gastrointestinal bleeding<br>5621<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Bleeding diverticulosis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Tuberculosis  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27, 1979, to 11/23, 1979, that (I) (we) lost saw the deceased alive on 11/23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>MARSHA Brown, MD  |  |  |  |  |  | DEGREE<br>MD   |  |  | 22c. DATE SIGNED<br>11-25-79   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARSHA Brown, MD   |  |  |  |  |  | 22e. ADDRESS<br>844 N. Charles Street  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>12/1/1979   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park                        |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Maryland  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 East North Avenue   |  |  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 29 1979                                    |  |  | 26. REGISTRAR'S SIGNATURE<br>Anthony A. Brady  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |               |  |  |  |  |  |  |  | REG. NO. 27320   |  |                    |  |
|--|--|---------------|--|--|--|--|--|--|--|--|--|--------------------|--|
| 1. FOR STATE REGISTRAR   |  |               |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR           |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Fannie FEINBERG   |  |               |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11 10 19 79 |  | 2b. HOUR 3:09 P.M. |  |
| 3. SEX female  |  | 4. RACE white |  | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 1, 1902   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.                    |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN   |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA  |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  |  |                    |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS   |  | 12b. KIND OF BUSINESS OR INDUSTRY CLOTHING   |  |                    |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |               |  |  |  |  |  |  |  |  |  |                    |  |
| 13a. STATE MARYLAND  |  |               |  | 13b. COUNTY BALTIMORE  |  |  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS APT. A 4001 FORDLIEGH RD. #21215   |  |                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST ELIAS SUSTER   |  |               |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA SUSTER      |  |  |  |  |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO  |  |               |  | 16b. SOCIAL SECURITY NO. 217-03-0560   |  |  |  | 17. INFORMANT MR. ALVIN BARD 8741 MEADOW HEIGHTS RD., RANDALLSTOWN, MD 21133   |  |  |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: Multiple Injuries<br>IMMEDIATE CAUSE (a) 8147<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |  |               |  |  |  |  |  |  |  |  |  |                    |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  |                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR 2:45 P.M. 11/10/79   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Pedestrian struck by automobile  |  |  |  |                    |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Reisterstown Rd/Patterson Ave, Balto City, MD   |  |  |  |                    |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .                                   |  |               |  |  |  |  |  |  |  |  |  |                    |  |
| ACTUAL SIGNATURE H. R. Guard   |  |               |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER  |  |  |  | DATE SIGNED 11/11/79   |  |  |  |                    |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.  |  |               |  | ADDRESS 111 Penn Street, Balto, MD 21201   |  |  |  |  |  |  |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  |               |  | 23b. DATE NOV. 12, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY BETH ISAAC ADATH ISRAEL |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND                                       |  |                    |  |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |               |  |  |  | 25a. DATE REC'D. BY REGISTRAR NOV 14 1979                  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                    |  |

NOV 1 1928

## CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MAX FELDMAN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 17 79</b><br>2b. HOUR<br><b>10:30 PM</b>  |  |   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 31, 1903</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT PROP.</b>   |  |   |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   | 13c. STREET ADDRESS<br><b>130 Slade Ave #409</b>                                     | 13d. INSIDE CITY LIMITS<br><input checked="" type="checkbox"/>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HASKELL FELDMAN</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA UNKNOWN</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214 18 1627</b>  | 17. INFORMANT<br>ADDRESS<br><b>MRS. SYLVIA FELDMAN 130 SLADE AVE. ( 21208)</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary failure</b><br><b>4410</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hepatic and renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ruptured Dissecting Abdo. Aortic Aneurysm - repaired</b> |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.  |  |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>11/1/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ruptured Abdo Aortic Aneurysm</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |   |  |   |
| 22b. SIGNATURE<br><b>K. E. Shaw-Taylor</b>   |  |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/17/79</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR K. E. Shaw-Taylor</b>   |  |   | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/18/79</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON CEM</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS</b>   |  | 6010 REISTERSTOWN RD.<br>BALTIMORE, MD. ( 21215)  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1979</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |

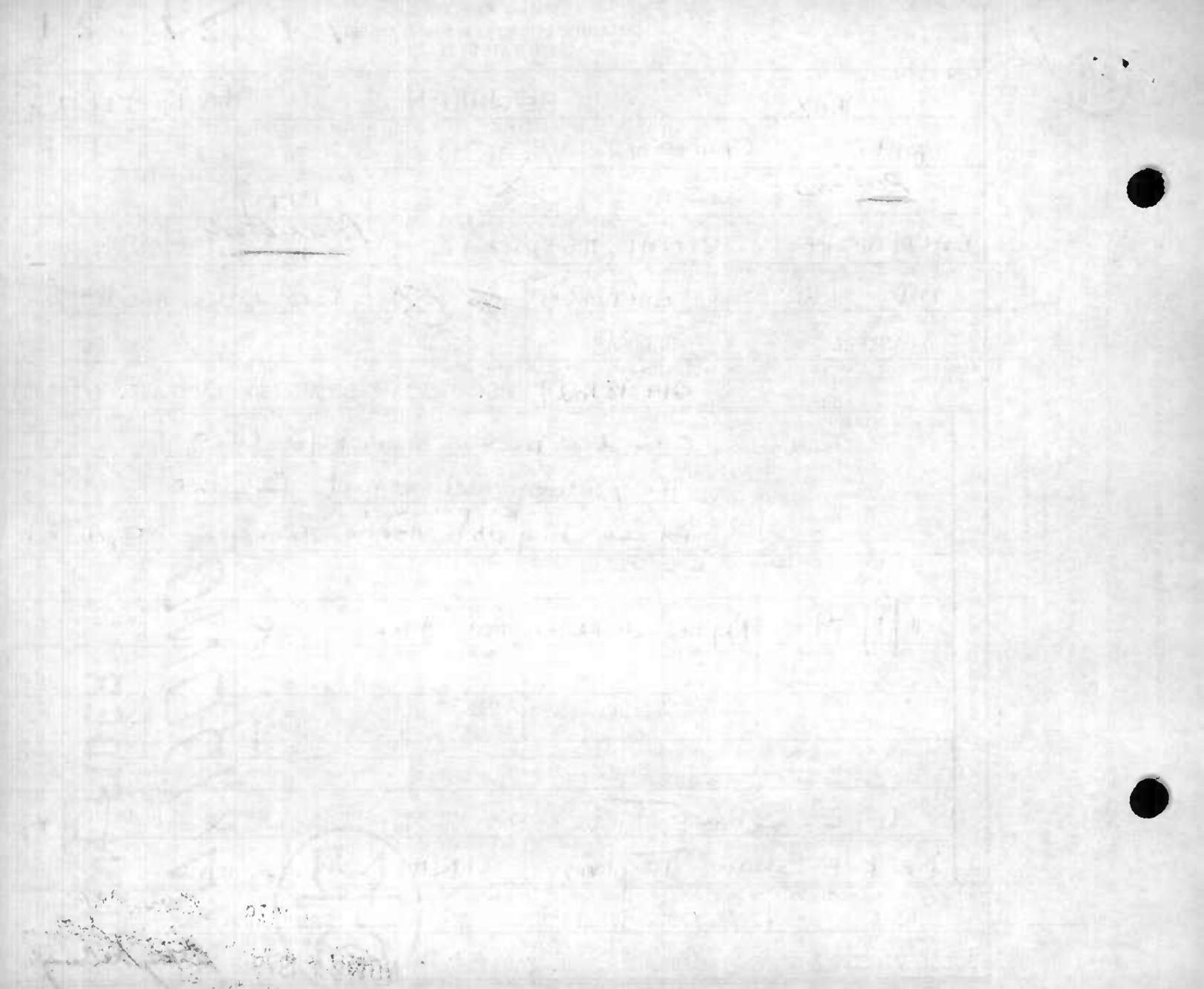
MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

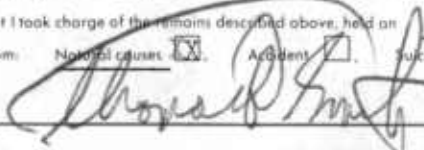
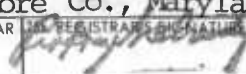
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |                              |  |  |
|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO. 7 9 2 7 3 2 2  |  |  |  |  |  |   |  |  |  |  |  |                              |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>WILLIAM  |  |  | MIDDLE<br>Conley   |  |  | LAST<br>FINK  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>11-17-79 |  |  | 2b HOUR<br>11:55PM<br>M      |  |  |
| 3 SEX<br>Male  |  |  | 4 RACE<br>Caucasian   |  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 26, 1904   |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS                  |  |  | 7 UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |  |  |  |  |                              |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home & Hospital |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Principal   |  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Education   |  |  |  |  |  |                              |  |  |
| 13a STATE<br>Maryland  |  |  | 13b COUNTY<br>Anne Arundel  |  |  | 13c CITY OR TOWN<br>Pasadena   |  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  | 13e STREET ADDRESS<br>1653 Colony Rd.          |  |  | 21122                        |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Edward Fink  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sadie Neiman  |  |  |  |  |  |   |  |  |  |  |  |                              |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>- - -   |  |  | 17 INFORMANT<br>Carrie M. Fink   |  |  | ADDRESS<br>Same as #13  |  |  |  |  |  |                              |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTASIS DISEASE TO LIVER<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CARCINOMA OF THE LUNG<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |                              |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |                              |  |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |                              |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |  |  |  |                              |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |  |  |  |                              |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |                              |  |  |
| 22b SIGNATURE<br>H. Al - midan   |  |  | DEGREE<br>MD  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  |  | 22c DATE SIGNED<br>11-17-79   |  |  |  |  |  |                              |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. H. ALAMIDANI MD  |  |  | 22e ADDRESS<br>N. BROADWAY BALTIMORE, MARYLAND 21231  |  |  | CHURCH HOSPITAL CORPORATION X X 100  |  |  |   |  |  |  |  |  |                              |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b DATE<br>11/20/1979  |  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Quickels Church Cem.  |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Coneago, York, Pa.   |  |  |  |  |  |                              |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Mc Cully F.H. Mtn. & Tick Neck Rds.; Pasadena, Md.  |  |  | ADDRESS<br>21122  |  |  | 25a DATE REC'D. BY REGISTRAR<br>NOV 19 1979  |  |  | 25b REGISTRAR'S SIGNATURE<br>Ricky McCreedy   |  |  |  |  |  |                              |  |  |

MEDICAL CERTIFICATION





REG. NO.

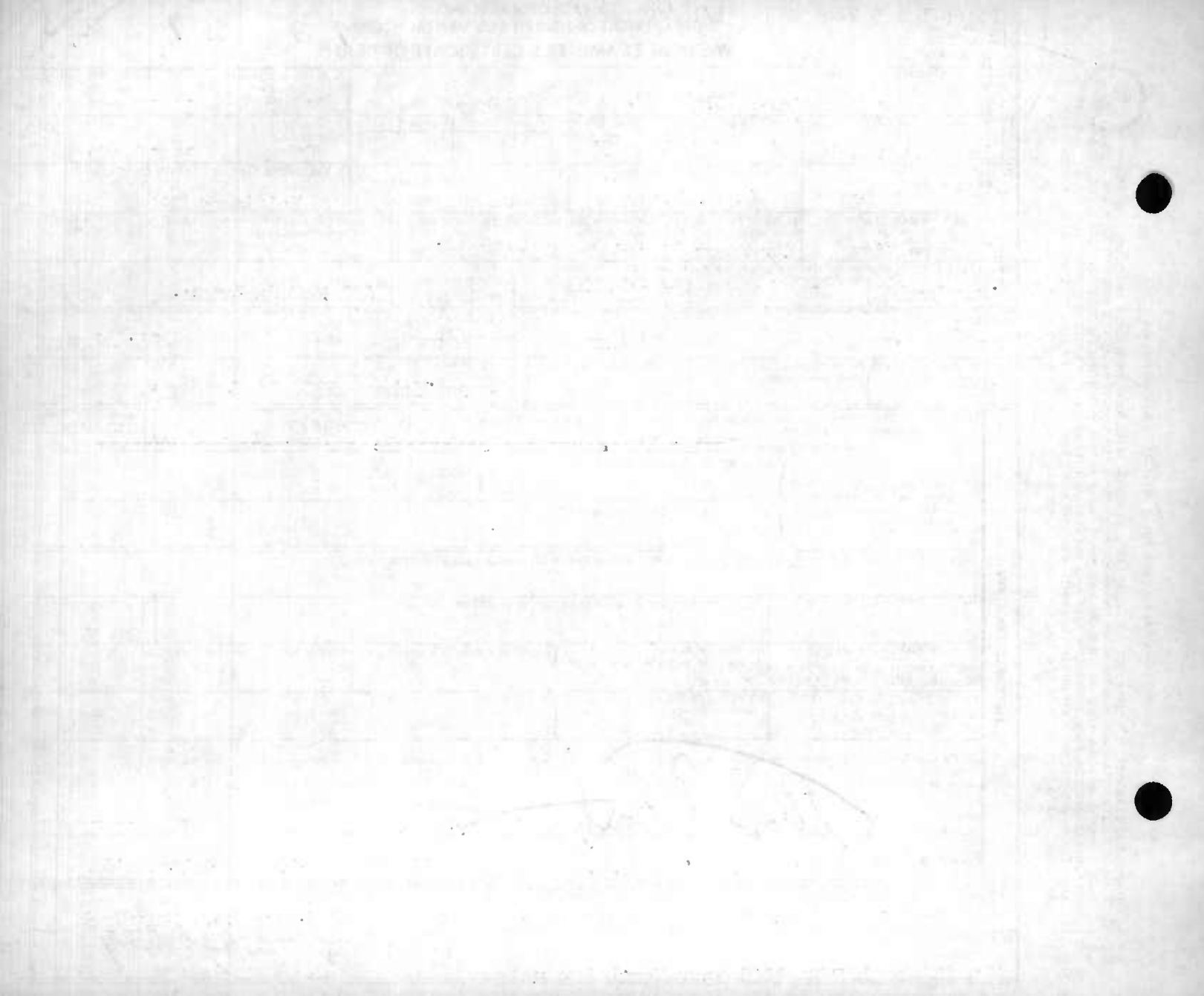
|   |                         |   |   |   |                     |
|---|-------------------------|---|---|---|---------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>(Freddie) Fred T. Fisher</b>  |                         | 20. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 18 1979</b>   |   | 2b. HOUR<br><b>M</b>  |                     |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 3 28</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 8. IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Northern District Police Station</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                     |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Fisher</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Victoria Dillahunt</b>  |   | 16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br><b>James Fisher 5224 Linden Hgts.</b>   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fatty liver &amp; arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>5718<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                |                         |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |   |   |                     |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                     |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                     |
| 22. I certify that I took charge of the remains described above; held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |   |   |                     |
| ACTUAL SIGNATURE<br>   |                         | TITLE (SPECIFY)<br>M.D. Deputy Chief  |   | DATE SIGNED<br>11/18/79   |                     |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |                         | ADDRESS<br><b>111 Penn St. Balto., MD.</b>  |   |   |                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>11/26/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |                     |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |                         | ADDRESS<br><b>1101 East North Avenue</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1979</b>   |                     |
| 25b. REGISTRAR'S SIGNATURE<br>   |                         |   |   |   |                     |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER BY TELEPHONE. IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 19, GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP\_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
30M 7/73



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 3 2 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME  
(TYPE OR PRINT)

ROANNA

MIDDLE

LAST

Fisher

2a. DATE OF DEATH

MONTH DAY YEAR  
11/16/79

2b. HOUR

12.50 PM

3. SEX

F

4. RACE

W

5. DATE OF BIRTH

MONTH DAY YEAR  
APRIL 29, 1908

6. AGE (IN YEARS LAST BIRTHDAY)

71 YRS

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

WEST VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

DOR. LUTHERAN A. Ashburn St.

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

PRINCE GEO.

13c. CITY OR TOWN

ADELPHI

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

2302 APACHE STREET XXXXXX

XXXXXXXXXXXXXXX

14. FATHER'S NAME

FIRST

HARRY

MIDDLE

LAST

PICKERING

15. MOTHER'S MAIDEN NAME

FIRST

LILLIAN

MIDDLE

KENDALL

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17. INFORMANT

217-44-4182

ADDRESS

ALLAN J. FISHER

SAME AS 13

HUSBAND

HUSBAND

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

5990

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Septicemia with shock

DUE TO, OR AS A CONSEQUENCE OF

(b) Urinary tract infection

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

hours

days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Cerebro-vascular accident.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/16/79, 1979, to 11/16/79, 1979, that (I) (we) lost saw the deceased alive on 11/16/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Sujeta Sapsiri

DEGREE

M.D.

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

11/16/79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SUJETA SAPSIRI

22e. ADDRESS

Lutheran Hospital of Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

11/19/79

23c. NAME OF CEMETERY OR CREMATORY

SUSQUEHANNA MEMORIAL

23d. LOCATION

GDN'S YORK

COUNTY

YORK

STATE

PA

24. FUNERAL DIRECTOR

NAME

FRANCIS J. COLLINS

500 UNIV. BLVD., W., SILVER SPRING, MD. 20901

25a. DATE REC'D. BY REGISTRAR

NOV 19 1979

25b. REGISTRAR'S SIGNATURE

History McCreedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

COAST

APRIL 22, 1962

BALTIMORE

U.S.

WEST VIRGINIA

BALTIMORE

WYOMING TRACE-SEE

HOUSTON

2200 ADAMS STREET

KNOXVILLE

LEWIS

HICKORY

LEWIS

KNOXVILLE

217-44-4182

ALAN J. FERGUSON

SALE AS IS

HICKORY

SECRET

17/19479

WORK

TA

200 UNIV. ST. BALTIMORE, MD. 20901

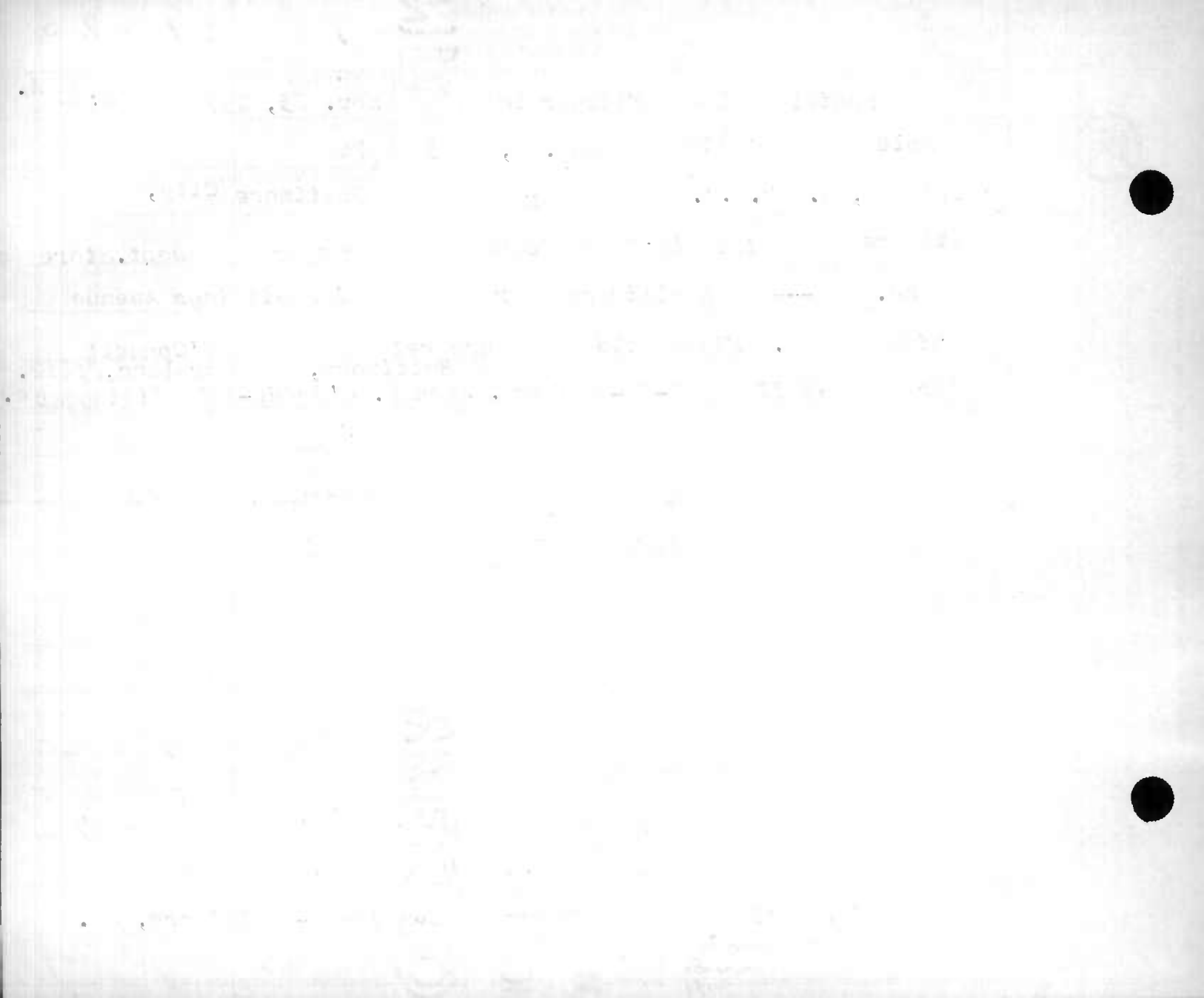
APR 22 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 9 2 7 3 2 5   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Daniel Leo Fitzgerald</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 23, 1979</b>   |  | 2b. HOUR<br><b>4:30</b> A.M.   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 4, 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>102 Gittings Avenue</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Wrapper</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel M. Fitzgerald</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret O'Connell</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 17. INFORMANT <b>Baltimore,</b> ADDRESS <b>Maryland, 21212.</b><br><b>Mrs. John F. O'Grady-102 Gittings Ave.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>arteriosclerotic C.V. disease</b><br>20yr<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>arterial hypertension</b><br>25+yr<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6hr</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Oct 19, 53</b> , to <b>Nov 22, 1979</b> , that (I) (we) lost saw the deceased alive on <b>Nov 23, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Fredrick J. Vollmer, M.D.</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11-23-79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FREDERICK J. VOLLMER</b>  |  |   |  | 22e. ADDRESS<br><b>6100 York Rd Baltimore, Md. 21212</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/26/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery - Baltimore, Md.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John A. Moran, Inc.</b>  |  |   |  | ADDRESS<br><b>3000 E. Baltimore St.</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1979</b>   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 9 2 7 3 2 6  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Baby Girl FITZPATRICK  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 22 79   |  |   |  |
| 3. SEX<br>Female   |  |   |  | 2b. HOUR<br>6:22 P.M.  |  |   |  |
| 4. RACE<br>Cauc.   |  |   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 8 79   |  |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>Newborn YRS.  |  |   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>15   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  |  |   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL               |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>none  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md 13b. COUNTY Baltimore 13c. CITY OR TOWN Overlea  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Timothy Fitzpatrick   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Devlin  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO<br>none  |  |   |  |
| 17. INFORMANT ADDRESS<br>Mr. Timothy Fitzpatrick, 4349 Robertson Ave.  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u><br>7585<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Prematurity</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Probable trisomy syndrome</u>                          |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost <u>see the deceased alive on</u> _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/23/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Anthony P. ARZ  |  |   |  | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/15/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltm., Maryland   |  |
| 24. FUNERAL DIRECTOR Witzke Funeral Home, 1630 Edmondson Ave., Balto., Md 21228  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 18 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

900 CANTON AVE. BALTIMORE, MD. 21229

01018129





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 3 2 7  
REG. NO.

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>AUGUSTUS A. FLEET, JR. |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 28, 1979 |  |  | 2b. HOUR<br>10:04 PM   |  |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Negro   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>11 5 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                        |  | # UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD         |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY       |  |

|   |  |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|--|---|--|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>915 North Linwood Avenue |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Augustus A. Fleet, Sr.   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida Muriel             |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-01-9028 |  | 17 INFORMANT<br>ADDRESS<br>Sylvia B. Fleet 915 N. Linwood Avenue |  |   |  |   |  |

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>             |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>lobular carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
Diabetes Mellitus

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |

22. I certify that (I) (this hospital) attended the deceased from 11-24 19 79 to 11-28 19 79, that (I) (we) lost saw the deceased alive on 11-28 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|   |  |              |  |  |  |                              |  |
|---|--|--------------|--|--|--|------------------------------|--|
| 22b. SIGNATURE<br><u>Frank H. March</u>                 |  | DEGREE<br>MD |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/28/79 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANK H. MARCH |  |              |  | 22e. ADDRESS<br>JHH - 601 N Broadway Balt 2205   |  |                              |  |

|  |  |                        |  |   |  |   |  |
|--|--|------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>12/1/1979 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Maryland |  |
|--|--|------------------------|--|---|--|---|--|

|  |  |         |  |  |  |  |  |
|--|--|---------|--|--|--|--|--|
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 East North Avenue |  | ADDRESS |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 30 1979 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Brady</u> |  |
|--|--|---------|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



WELV 8 012 4

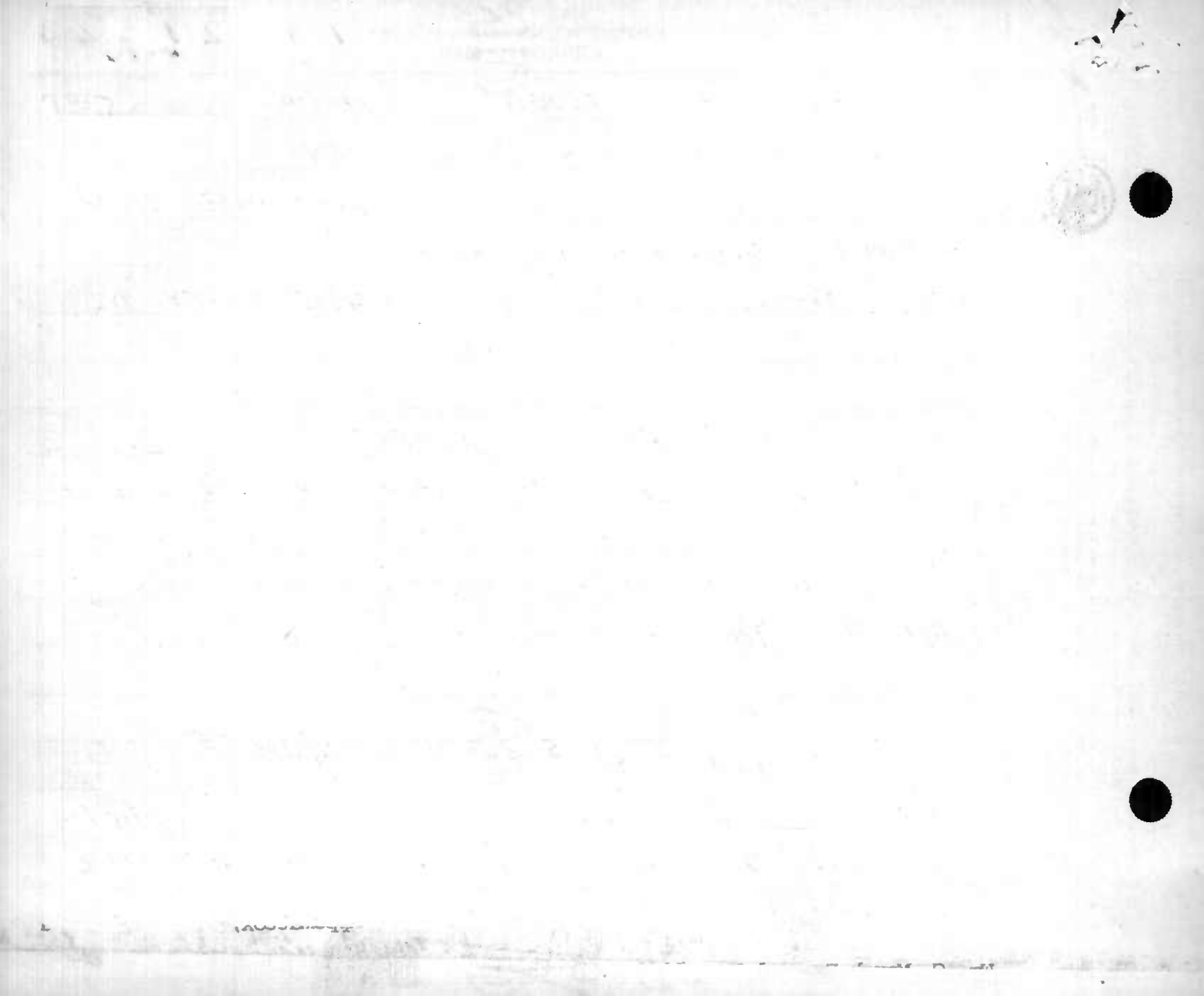
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 9 2 7 3 2 8  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BETTIE A FLOOD</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11/15/79</b>   |  | 2b. HOUR <b>5:20 P.M.</b>   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>BLACK</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 23 91</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE 21214 MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>4915 GILRAY DR. 21214</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Patterson</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bock</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>?</b>   |  | 17. INFORMANT ADDRESS <b>Peter Flood 4915 Gilray Drive</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>486-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia + @ Bronchial artery thrombosis</b>                              |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>45 minutes</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CARDIOMEGALY - THROMBOSIS @ Bronchial artery</b>   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>11/15/79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Thrombosis @ Bronchial artery</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/15 2PM 1979</b> to <b>11/15/79 5PM</b> that (I) (we) lost saw the deceased alive on <b>11/15</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Sharon K. Moore</b> DEGREE <b>MD</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>11/15/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AURAM KIRAL</b>  |  |   |  | 22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>11/19/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Appomattox Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Appomattox, Virginia</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March Funeral Home/1101 E. North Ave.</b>   |  |   |  | 25a. DATE RECD. BY REGISTRAR <b>NOV 20 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Sharon K. Moore</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |   |  | 7 9 2 7 3 2 9   |  |  |
|--|--|--|---|--|--|---|--|---|--|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |   |  | REG. NO.   |   |  |   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Virginia Flowers</b>  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>Nov.</b> DAY <b>19</b> YEAR <b>79</b>  |   |  |   | 2b. HOUR<br><b>5 AM</b>  |   |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>Negro</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>FEB</b> DAY <b>6</b> YEAR <b>1957</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>22</b> YRS.                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                       |  | 8. IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b>                  |  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD                         |  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>UNEMPLOYED</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   | 13e. STREET ADDRESS<br><b>3468 SPELIMAN ROAD</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>CHARLES</b> MIDDLE <b></b> LAST <b>IRELAND</b>   |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>BARBARA</b> MIDDLE <b></b> LAST <b>MATHEWS</b>  |   |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS<br><b>MR. WILBERT FLOWERS 3468 SPELIMAN ROAD</b>             |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b>  |  |  |   |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 min.</b> |  |  |
| 3481<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Aspiration Pneumonia</b>  |  |  |   |  |  |   |  |   |  | <b>2 weeks</b>  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebral Hypoxia</b>  |  |  |   |  |  |   |  |   |  | <b>2 1/2 months</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (i)<br><b>Severe hyperthermia</b>   |  |  |   |  |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>9/4/79</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>morbid Obesity</b> |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>         |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |   |  |   |  |  |
| 22a. I certify that <b>Adam Billetus</b> attended the deceased from <b>9/2/79</b> , 19 <b></b> , to <b>11/19/79</b> , 19 <b></b> , that <b>we</b> last saw the deceased alive on <b>11/18/79</b> , 19 <b></b> , and that in <b>our</b> opinion death occurred on the date and hour and from the causes stated above. <b>we</b> (did) <b>not</b> view the body after death. |  |  |   |  |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Adam Billetus</b>   |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>11/19/79</b>                                     |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Adam Billet</b>  |  |  |   |  | 22e. ADDRESS<br><b>Mercy Hospital, Balto. md.</b>  |   |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>11/23/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CEMETERY</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>LEWIS T. GWYNN</b> ADDRESS <b>4517 PARK HEIGHTS AVENUE</b>   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1979</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>History McCreedy</b>                   |  |   |  |  |

MEDICAL CERTIFICATION

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US of A

CHAIRMAN

UNEMPLOYED

WOMEN'S SOCIETY

BALTIMORE

3008 ELLIOTT ROAD

BALTIMORE

BALTIMORE

CHAIRMAN

BALTIMORE

BALTIMORE

BALTIMORE

MR. WILLIAM WILSON 3008 ELLIOTT ROAD

NO



BALTIMORE

BALTIMORE

MT. VERNON CEMETERY

11/25/17

BALTIMORE

NOV 2 1917

4517 PARK HEIGHTS AVENUE

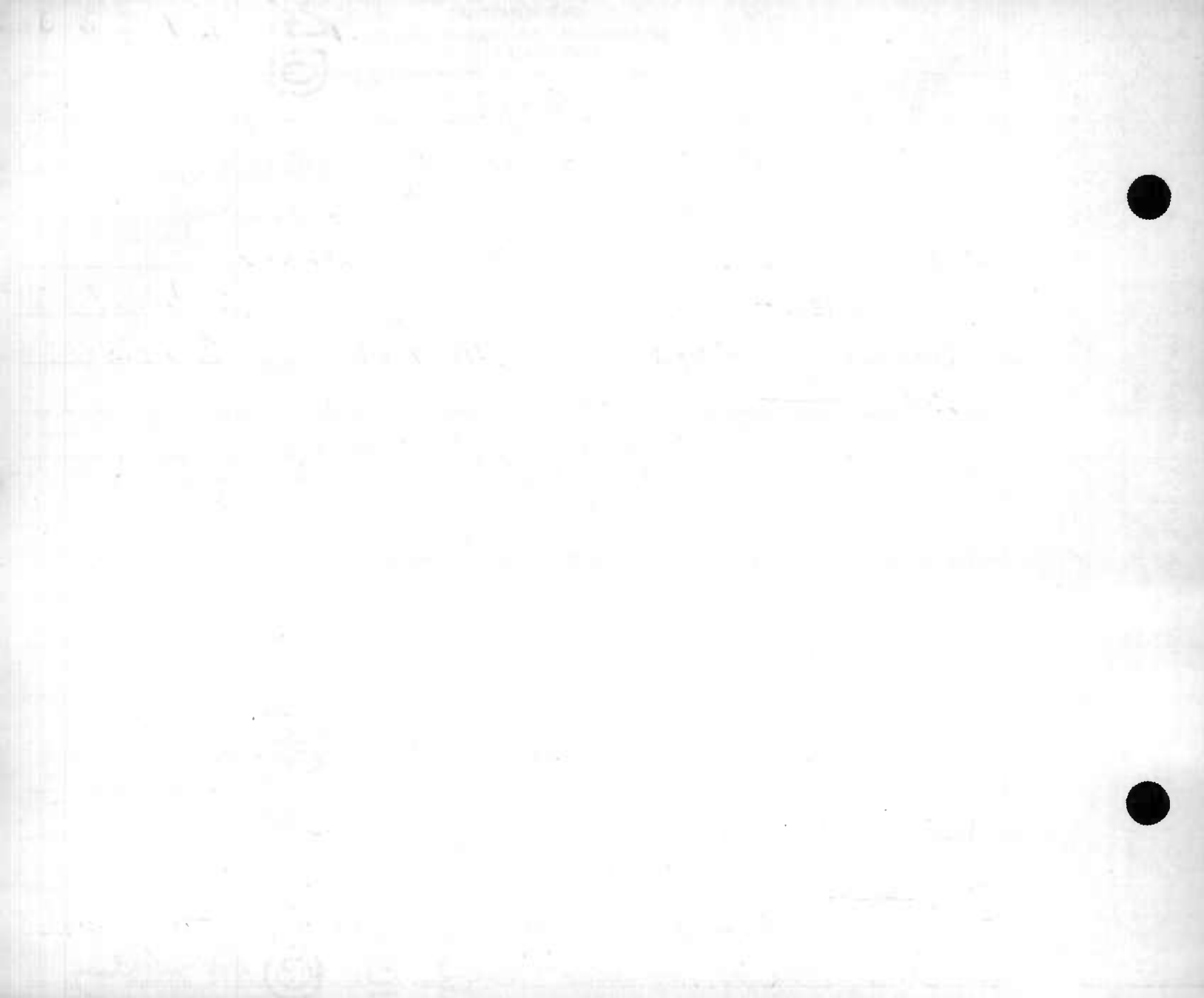
1212 T. GARDIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 9 2 7 3 3 0  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.   |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Rudolph Floyd</i>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>11-30-79</i>  |  | 2b. HOUR<br><i>1 PM</i>   |   |
| 3 SEX<br><i>MALE</i>  |  | 4 RACE<br><i>BLACK</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>6-29-24</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>55</i> YRS   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY MD.</i>  |   |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>laborer</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13b. STREET ADDRESS<br><i>3423 Piedmont Ave</i>   |   |
| 13a. STATE<br><i>MD.</i>  |  | 13b. COUNTY<br><i>Balt</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>  |  |   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Daniel Floyd</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mildred Combs</i>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><i>218187433</i>  |  | 17 INFORMANT<br>ADDRESS<br><i>Chart.</i>   |  |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>1579 METASTATIC CARCINOMA:</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>PRIMARY ROB. PANCREAS</i><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____                                     |  |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-16-1979</i> to <i>11-30-1979</i> , that (I) (we) last saw the deceased alive on <i>11-30-1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |   |
| 22b. SIGNATURE<br><i>Abdul Samad Khan</i>   |  |   |  | DEGREE<br><i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>11-30-79</i>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ABDUL SAMAD KHAN</i>  |  |   |  | 22e. ADDRESS<br><i>LUTHERAN HOSPITAL OF MD</i>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE<br><i>12/6/79</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Union Ch. Co</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Easton TRC MD</i>  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>George Daskal</i>   |  |   |  | ADDRESS<br><i>31 Jonnville St. Easton</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 17 1979</i>   |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Henry McCreedy</i>  |  |   |   |



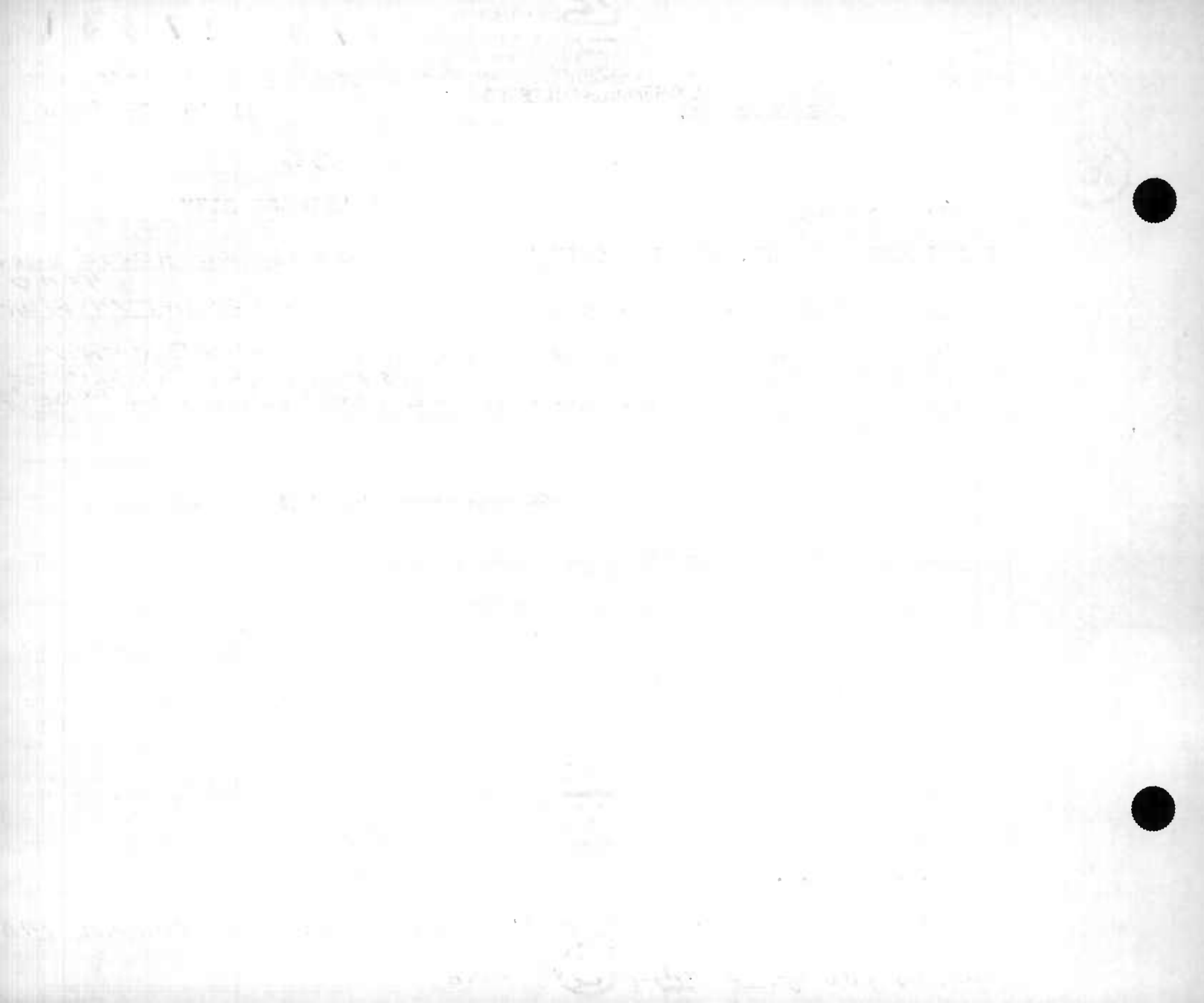


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 7 9 2 7 3 3 1                                   |  |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST <u>ANNIE</u> MIDDLE <u>E. CATHERINE</u> LAST <u>FOGLESONG</u>                                       |  |   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
|   |  | <u>FOGLESONG XXXXX</u>  |  |   |  | 11 23 79  |  | 8:50 PM  |  |   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                                 |  |
| F   |  | W   |  | FEB 22 1923   |  | 56 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |   |  |
| MARYLAND  |  | USA   |  |   |  | BALTIMORE CITY MD.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |   |  |
| BALTIMORE   |  | ST. AGNES HOSPITAL  |  |   |  | HOUSEWIFE   |  | HOUSEWORK  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS   |  |  |  |   |  |
| 13a. STATE  |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS   |  |  |  |   |  |
| MD.   |  | CARROLL WESTMINSTER   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 2704 ROBERT ARTHUR ROAD   |  |  |  |   |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |  |   |  |
| FIRST MIDDLE LAST   |  |   |  | FIRST MIDDLE LAST   |  |   |  |  |  |   |  |
| GEORGE W. KEENEY  |  |   |  | MYRTLE DINTERMAN  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS  |  |   |  |
| NO  |  |   |  | 578-20-9454   |  | 2157 ARTHUR RD. WESTMINSTER MD.                                     |  | LUTHER L. FOGLESONG 2704 ROBERT                                |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u>  |  |   |  |   |  |   |  |  |  |   |  |
| 430 -   |  |   |  |   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF <u>Intracerebral bleeding</u>  |  |   |  |   |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF <u>Leaking Anurym. Rt. internal carotid artery</u>   |  |   |  |   |  |   |  |  |  |   |  |
| (c)   |  |   |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 11/21/79  |  | Leaking Anurym Rt internal carotid  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |   |  |
|   |  | P.M. 19   |  |   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY   |  | STATE   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  |   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> 19 <u>79</u> , to <u>11/23</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/23</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED   |  |   |  |
| <u>Le Bshal</u>   |  |   |  |   |  |   |  | 11/23/79.  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |   |  |  |  |   |  |
| U.B. SHAH M.D.  |  |   |  | St Agnes<br>900 Calhoun's Avenue - Balto MD 21229   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY   |  | STATE   |  |
| BURIAL  |  | 1979  |  | BAUST CEMETERY  |  | TYRONE  |  | CARROLL  |  | MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |
| Richard Little  |  | 34 Maple Ave<br>Pa. 17340   |  | NOV 28 1979   |  |   |  |  |  |   |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMM - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 3 3 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES L FOLK, Sr.</b>  |   |   | 2a. DATE OF DEATH MONTH <b>11</b> / DAY <b>10</b> / YEAR <b>79</b>                              |  | 2b. HOUR <b>8:41 PM</b>   |
| 3. SEX<br><b>Male M</b>   | 4. RACE<br><b>White W</b>   | 5. DATE OF BIRTH<br>MONTH <b>Feb.</b> DAY <b>7</b> YEAR <b>1925</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b>  |  | 7. UNDER 5 YEARS<br>MONTHS <b>YES</b> DAYS <b>YES</b> HOURS <b>YES</b> MIN. <b>YES</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY Baltimore MD.</b>                               |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b>           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Post Office</b>                              |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Md</b> 13c. COUNTY <b>Baltimore</b> 13d. CITY OR TOWN <b>BALTIMORE</b>  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>1506 Pinnacle Rd</b>                                       |   |
| 14. FATHER'S NAME<br>FIRST <b>Ray</b> MIDDLE <b>Folk</b> LAST <b>Folk</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Deist</b> LAST <b>Deist</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>WW11 204-16-5513</b>   | 17. INFORMANT ADDRESS<br><b>Mrs Gladys M. Folk, Same as #13e</b>                                |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY FAILURE</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPTIC SHOCK.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>METASTATIC OAT CELL CA.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 Hr</b><br><b>6 months</b> |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11-8-79</b> 19____, to <b>11-10-79</b> 19____, that (1) <del>was</del> lost<br>saw the deceased <del>die</del> on <b>11-10-79</b> 19____, and that in (my/our) opinion death occurred on the date and hour and from the causes stated<br>above. (1) <del>we</del> (did/did not) view the body after death.  |   |   |   |  |   |
| 22b. SIGNATURE<br><b>R. Patel MD</b>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>11-10-79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HASMUKH R PATEL</b>   |   | 22e. ADDRESS<br><b>BALTO. Md 21239<br/>5601 LOCHRAN BLVD.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |   | 23b. DATE<br><b>11-13-79</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Salisbury Cemetery</b>                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Salisbury, Somerset Pa.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |   | ADDRESS <b>1050 York Rd.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1979</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

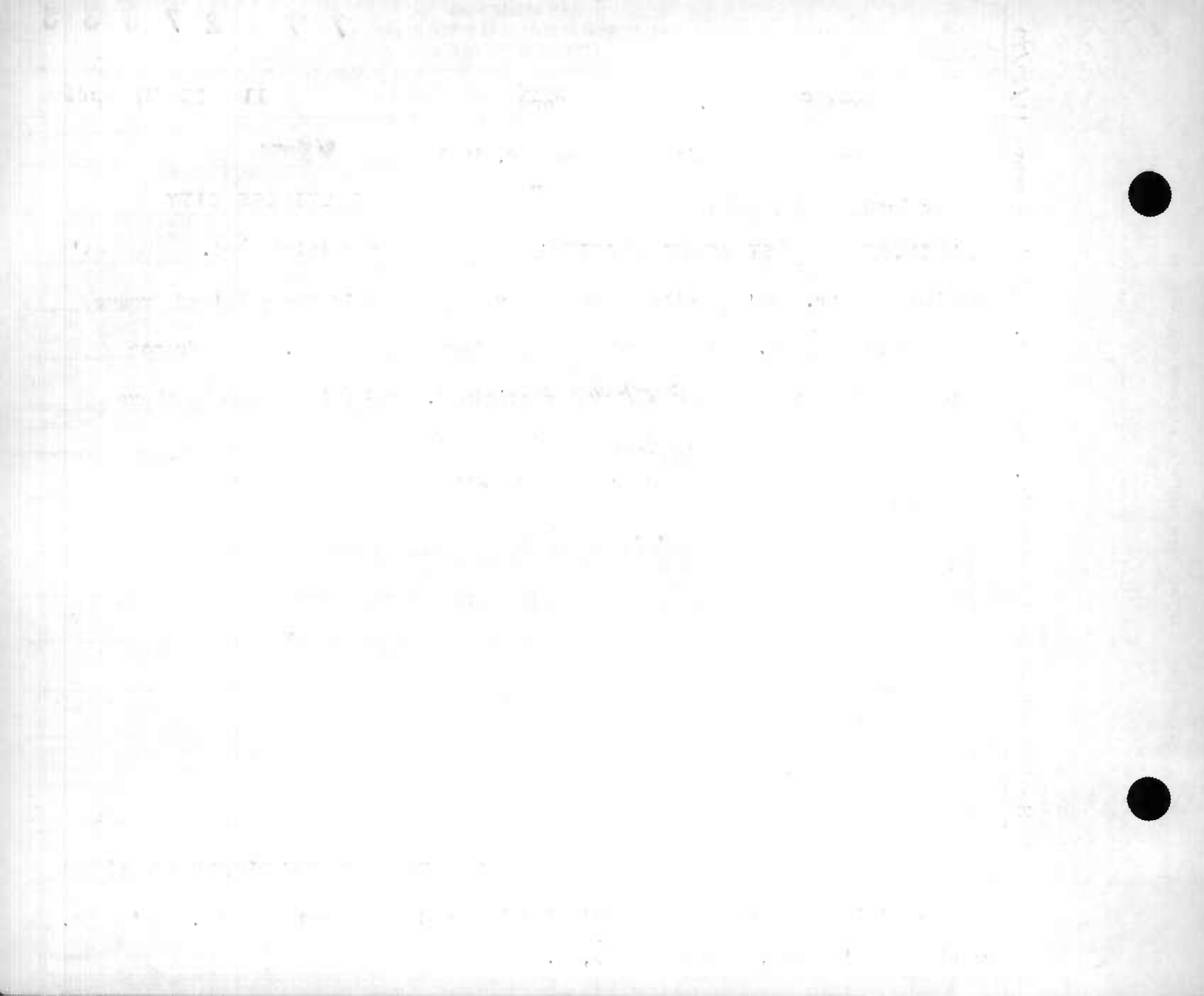
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Medical Examiner Notified by St. Agnes Hosp. and did approve 11/22/79

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |                            |  |  | REG. NO.                                     |  |
|---|--|---|--|---|--|---|----------------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lawrence L. Ford</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 22 79</b> |   | 2b. HOUR<br><b>4:06 PM</b> |  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov 2, 1901</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS  |                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist Ret.</b>       |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Gov't</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Pr. Geo's</b>   |  | 13c. CITY OR TOWN<br><b>College Park</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            | 13e. STREET ADDRESS<br><b>9014 Rhode Island Avenue</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert G. Ford</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Flora B. France</b>   |  |   |                            |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-8678A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Letitia B. Ford (wife) same as above</b>                         |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Pulmonary Arrest</b><br><b>5789</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Abdominal Obstruction</b><br>(c) <b>G.I. Bleeding</b> |  |   |  |   |  |   |                            |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |                            |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |                            |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                            |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                 |  |   |  |   |  |   |                            |  |  |  |  |
| 22b. SIGNATURE<br><b>R.G.A. BOLAND</b>  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |                            | 22c. DATE SIGNED<br><b>11-22-79</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R.G.A. BOLAND</b>   |  |   |  | 22e. ADDRESS<br><b>900 CATON AVE BALTIMORE MD 21229</b>   |  |   |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/24/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo's Md.</b>                    |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Francis Gasch's Sons, PA Hyattsville, Md.</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1979</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 3 3 4

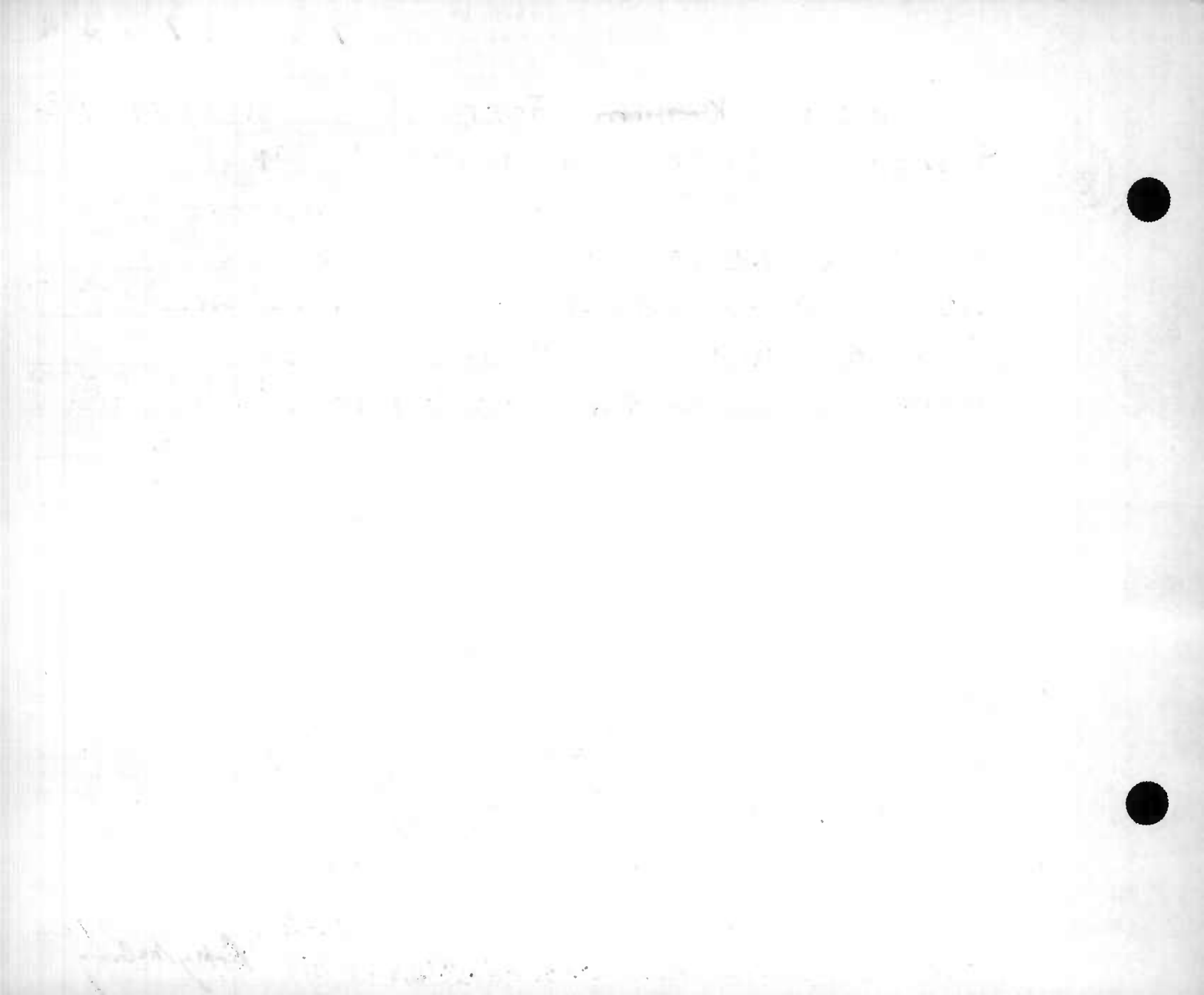
REG. NO.

|  |  |  |   |  |  |  |  |  |   |  |
|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Viola Kellam Ford   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 17 79                         |  |  | 2b. HOUR<br>9:40 AM  |  |  |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>white  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 11 1888   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wesley Home |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>unknown  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.   |  |  |   |  | 13b. COUNTY<br>unknown   |  | 13c. CITY OR TOWN<br>Baltimore                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Colie A. Kellam  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances K. Roberts    |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>unknown  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-07-66821 |  | 17 INFORMANT<br>ADDRESS<br>Wesley Home 2211 W. Rogers Ave<br>Balto. md |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular Disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>> 20 years<br>> 20 years. |  |  |   |  |  |  |  |  |   |  |
|  |  |  |   |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Chronic Organic Brain Syndrome   |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 11-17 19 79, to 11-17 19 79, that (1) (we) lost saw the deceased alive on 11-13 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Robert E. Roby M.D.  |  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/17/79   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT E. ROBY M.D.   |  |  |   |  |  | 22e. ADDRESS<br>8872 BELAIR RD. 21236  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE IF)<br>Burial  |  |  | 23b. DATE<br>11/20/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. md. |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BURGEE FUNERAL HOME  |  |  |   |  |  | ADDRESS<br>3631 FALLS  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1979   |   |  |
|  |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br>History Making   |  |  |   |  |

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(VRA 15, 4) 7/78

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 7 9 2 7 3 3 5   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| NANCY FORNEY  |  |   |  | 11 20 79 1:05A M  |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 6 1911   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MARYLAND  |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Tweddle  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>14-38-1144  |  | 17. INFORMANT<br>ADDRESS<br>Patsy Westmoreland 2547 Garrett Avenue  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 7854 CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>11/15/79  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>GANGRENE (R) FOOT   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/13, 19 79, to 11/20, 19 79, that (I) (we) lost saw the deceased alive on 11/20, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Maria E Tebbetts MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11/20/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARIA E TEBBETTS MD  |  |   |  | 22e. ADDRESS<br>SINAI HOSPITAL, BALTIMORE, MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/26/1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 East North Avenue   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1979  |  | 25b. SIGNATURE OF REGISTRAR<br>[Signature]   |  |

MEDICAL CERTIFICATION

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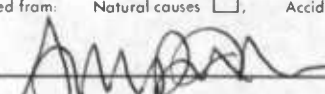

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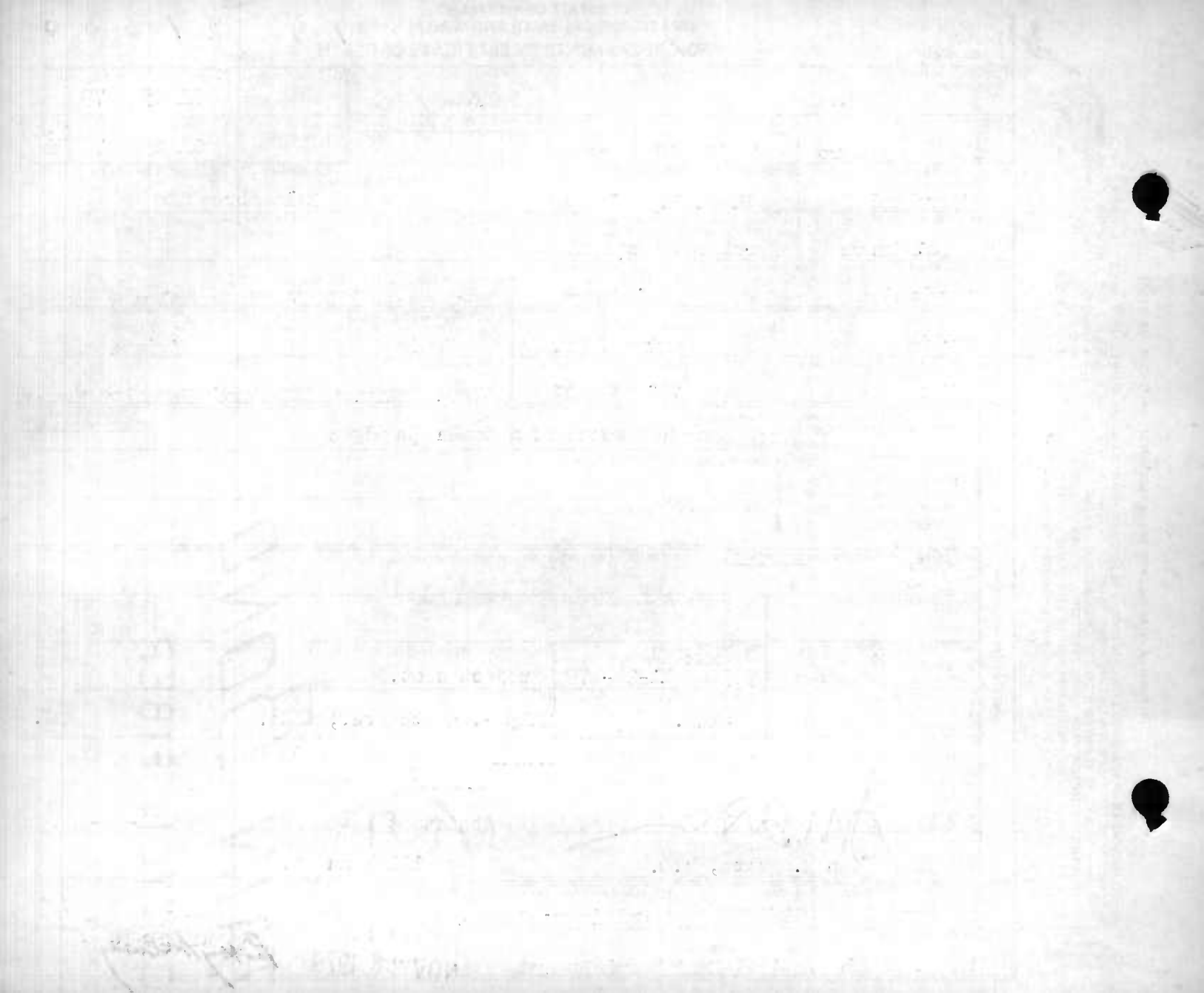
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 WORKS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |   |                  |   |  |   |  | REG. NO. 273336                              |  |
|--|-------------------------|---|--|---|------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CARLIE FORTUNE, Jr.</b>   |                         |   |  |   |                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 25 1979</b>        |  | 2b. HOUR<br><b>1:40</b>   |  |  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>negro</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 13 40</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>39 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 25 1979</b>   |  | 2d. HOUR<br><b>a</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  | 13e. STREET ADDRESS<br><b>1720 North Bentalou Street</b>                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Carlie Fortune, Sr.</b>   |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ionia Prince</b>  |                  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>213-36-0811</b>  |  | 17. INFORMANT ADDRESS<br><b>Ionia Fortune 1720 North Bentalou Street</b>  |                  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9660 IMMEDIATE CAUSE (a): Gunshot wound of abdomen (handgun)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                         |   |  |   |                  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |   |  |   |                  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |                  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>9:30 a.m. 11-24-1979</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot.</b>   |                  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>bldg.</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2115 W. North Ave., Balto. Md.</b>  |                  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |  |   |                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>  |                         | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |   |                  |   |  | DATE SIGNED<br><b>11-25-79</b>  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |                         | ADDRESS<br><b>111 Penn St.</b>  |  |   |                  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>12/1/1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 East North Avenue</b>   |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1979</b>   |                  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |                            |  |   |  |
|---|--|--|--|--|--|--|----------------------------|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 7 9 2 7 3 3 7  |  |                            |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH  |  |                            |  |   |  |
| LENORA (nmi) FORWOOD  |  |  |  |  | 11 17 79 11:30 AM  |  |                            |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |                            | 7. IF UNDER 1 YEAR   |   |  |
| Female  |  | WHITE  |  | 10/11/1903   |  | 76 YRS   |                            | MONTHS DAYS HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                            |  |   |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore City MD.   |                            |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                            | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |  |
| Baltimore   |  | Baltimore City Hospitals   |  |  |  | HOUSEWIFE  |                            |  |   |  |
| 13a. STATE  |  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN          |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |  |  |  |  | Balto.   |  | Dundalk                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |                            |  |   |  |
| Robert George Bill  |  |  |  |  | Jennie Hinkle  |  |                            |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.                         |  | 17. INFORMANT ADDRESS  |  |                            |  |   |  |
| No  |  |  | 214.24.0755                                      |  | Pauleen Hartner--Same as 13e   |  |                            |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |                            |  |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |                            |  |   |  |
| IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>  |  |  |  |  |  |  |                            |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____  |  |  |  |  |  |  |                            |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |  |  |  |                            |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |  |  |  |                            |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |  | 20a. AUTOPSY?  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |
|   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY                              |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                            |  |   |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR                         |  |  |  |                            |  |   |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY                             |  |  | 21f. LOCATION  |                            |  |   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | STREET CITY OR TOWN COUNTY STATE   |                            |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |                            |  |   |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE   |  |                            | 22c. DATE SIGNED   |   |  |
| William D. Suval, M.D.  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                            | 11/17/79   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  | 22e. ADDRESS   |  |                            |  |   |  |
| WILLIAM D. SUVAL  |  |  |  |  | 4606N 4940 Coston Ave, Baltimore   |  |                            |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION              |  | 23e. STATE  |  |
| Cremation   |  |  | 11/19/1979                                       |  | Loudon Park  |  | Baltimore                  |  | Md.   |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE |  |   |  |
| Walter B rooks Bradley Inc. Dundalk Md  |  |  |  |  | NOV 20 1979  |  | Patricia M. Brady          |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  | REG. NO.  |   |  |  |  |  |  |  |  |  |
|--|--|---|--|--|---|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William H Foster</b>  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>18</b> YEAR <b>79</b>                             |   |  |  |  | 2b. HOUR<br><b>12:30am</b>                     |  |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>N</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>19</b> YEAR <b>21</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS   |  |  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>              |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>165 S. Milton St</b>   |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Daniel</b> MIDDLE <b>Foster</b> LAST <b>Foster</b>   |  |   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Channie</b> MIDDLE <b>Patterson</b> LAST <b>Patterson</b> |   |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO<br><b>111-05-9902</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>BERTHA GAGAN 165 S Milton St</b>   |   |   |  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary artery</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Carcinoma lung c</b><br>(c) <b>metastasis.</b> |  |   |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Trachetomy, Gastrostomy.</b>   |  |   |  |  |   |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>difficulty swallowing</b>  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)   |   |   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |   |  |  |   |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>G. Talbot</b>   |  |   |  |  | DEGREE<br><b>MD.</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-18-79</b>            |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CH MALHOTRA</b>  |  |   |  |  | 22e. ADDRESS<br><b>900 CATON AVE BALTIMORE MD 21229</b>                                       |   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/24/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>115 AUGUST</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>BALTO MD</b> COUNTY <b>21230</b> STATE                         |  |  |  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>W P Hays</b> ADDRESS <b>2358 9th Ave SE</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patterson</b> |  |  |  |  |  |  |  |

BP

DHMM-16 20M  
(VRA 15, 4) 7/78





1910

THE  
OFFICE OF THE  
SHERIFF  
COUNTY OF  
SANTA FE  
NEW MEXICO

RECEIVED

1910



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |                                       |   |  |  |
|---|--|--|--|---|---|---|---------------------------------------|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |   |   |                                       |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Camilla A Foxwell</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 22, 1979</b>          |   |                                       |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>FEB 25, 1897<sup>AR</sup></b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>                                      |                                       | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                 |                                       |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John Hopkins Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                       | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><b>Maryland</b>   |  |  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Paul Thiel</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Camilla Schubert</b> |   |                                       |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-0813B</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr Paul W Foxwell Lusby, Md</b>   |   |   |                                       |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4413 EXTRA abdominal hernia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ruptured aneurysm of abd. aorta</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>several</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1.5 mths</b> |  |  |  |   |   |   |                                       |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>chronic thromboembolitis</b>   |  |  |  |   |   |   |                                       |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                                       |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |                                       |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7</b> , 19 <b>57</b> , to <b>11/22</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |  |  |   |   |   |                                       |   |  |  |
| 22b. SIGNATURE <b>[Signature]</b>   |  |  |  | DEGREE  |   |   |                                       | 22c. DATE SIGNED<br><b>11/23/79</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Jay Platt M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>406 Eastern Blvd Baltimore, Md.</b>  |   |   |                                       |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/26/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |                                       |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR SIGNATURE)<br><b>NOV 26 1979 [Signature]</b>  |   |   |                                       |   |  |  |



November 22, 1970

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |                               |  |   |  |
|--|--|---|--|---|--|--|-------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 7 9 2 7 3 4 0  |  |   |  |  |                               |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CLAIRE J FRANCKOWIAK  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 28 1979         |  |                               | 2b. HOUR<br>9:45 AM  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>02 20 47   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>32 YRS.                                 |                               | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U.M.H. University of Maryland |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |   |  |
| 13a. STATE<br>MD   |  |   |  |   | 13b. COUNTY<br>Harford                                       |  | 13c. CITY OR TOWN<br>Aberdeen |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FRANK BADUR   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>JEAN DICKERSON |  |                               |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212-48-5748   |  | 17. INFORMANT ADDRESS<br>Michael Frankowiak 626 Marjorie Lane   |  |  |                               |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>4239<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |                               |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>No Pericarditis, and Pericardial effusion   |  |   |  |   |  |  |                               |  |   |  |
| 19a. DATE OF OPERATION<br>11. 27. 79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Pericarditis  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                               |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                               |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11. 18. 19 79, to 11. 28. 19 79, that (I) (we) last saw the deceased alive on 11. 28. 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |                               |  |   |  |
| 22b. SIGNATURE<br>Ahmad  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |                               | 22c. DATE SIGNED<br>11. 28 79  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MIRZA M. AHMAD  |  |   |  | 22e. ADDRESS<br>U.M.H. BALTIMORE  |  |  |                               |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/1/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hills   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Balto. MD                |                               |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>John C. Wood  |  |   |  | ADDRESS<br>1211 Chesaco Ave   |  | 25a. DATE REC'D BY REGISTRAR<br>DEC 4 1979                                 |                               | 25b. REGISTRAR'S SIGNATURE   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

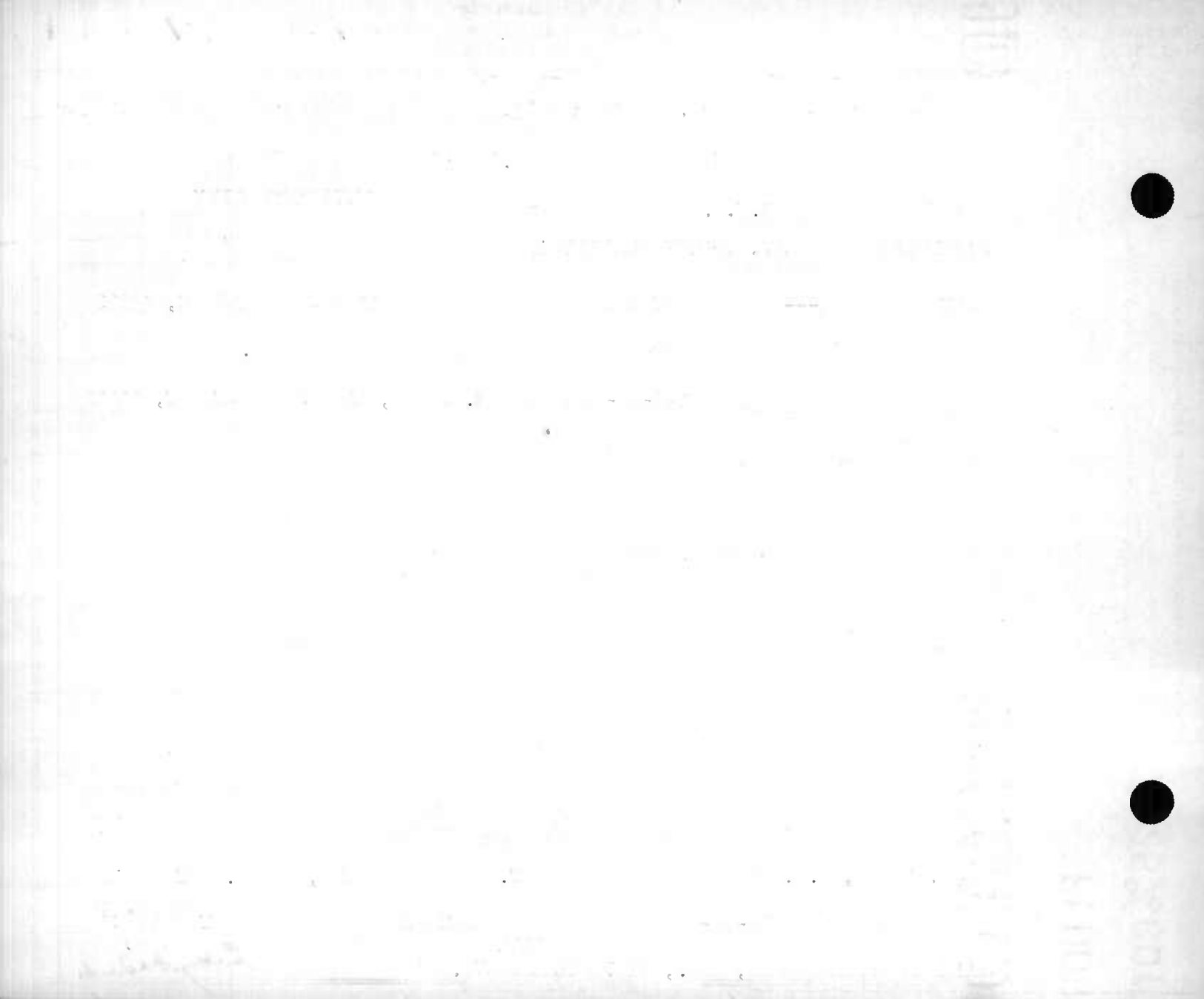
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 7 9 2 7 3 4 1   |  |   |  |
|--|--|--|--|---|--|---|--|
| FOR<br>1 - STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>MINNIE V. FRANKLIN</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 15, 1979</b>   |  | 2b. HOUR <b>5 PM</b>  |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>09 02 03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MARYLAND</b>   |  | 13b. COUNTY <b>---</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN STORMS</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>  |  | 13e. STREET ADDRESS <b>1304 JAMES STREET, 21223</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>216-10-9485</b>  |  | 17. INFORMANT ADDRESS <b>IDA H. FIELD, 1304 JAMES STREET, 21223</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br><b>410 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 10</b> 19 <b>79</b> , to <b>Nov 15</b> 19 <b>79</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>Nov 15</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>E. Myers M.D.</b> DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED <b>11/15/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. MYERS, M.D.</b>  |  |  |  | 22e. ADDRESS <b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>11-17-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEMETERY</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>WOODLAWN BALTIMORE MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.,</b>   |  | ADDRESS <b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

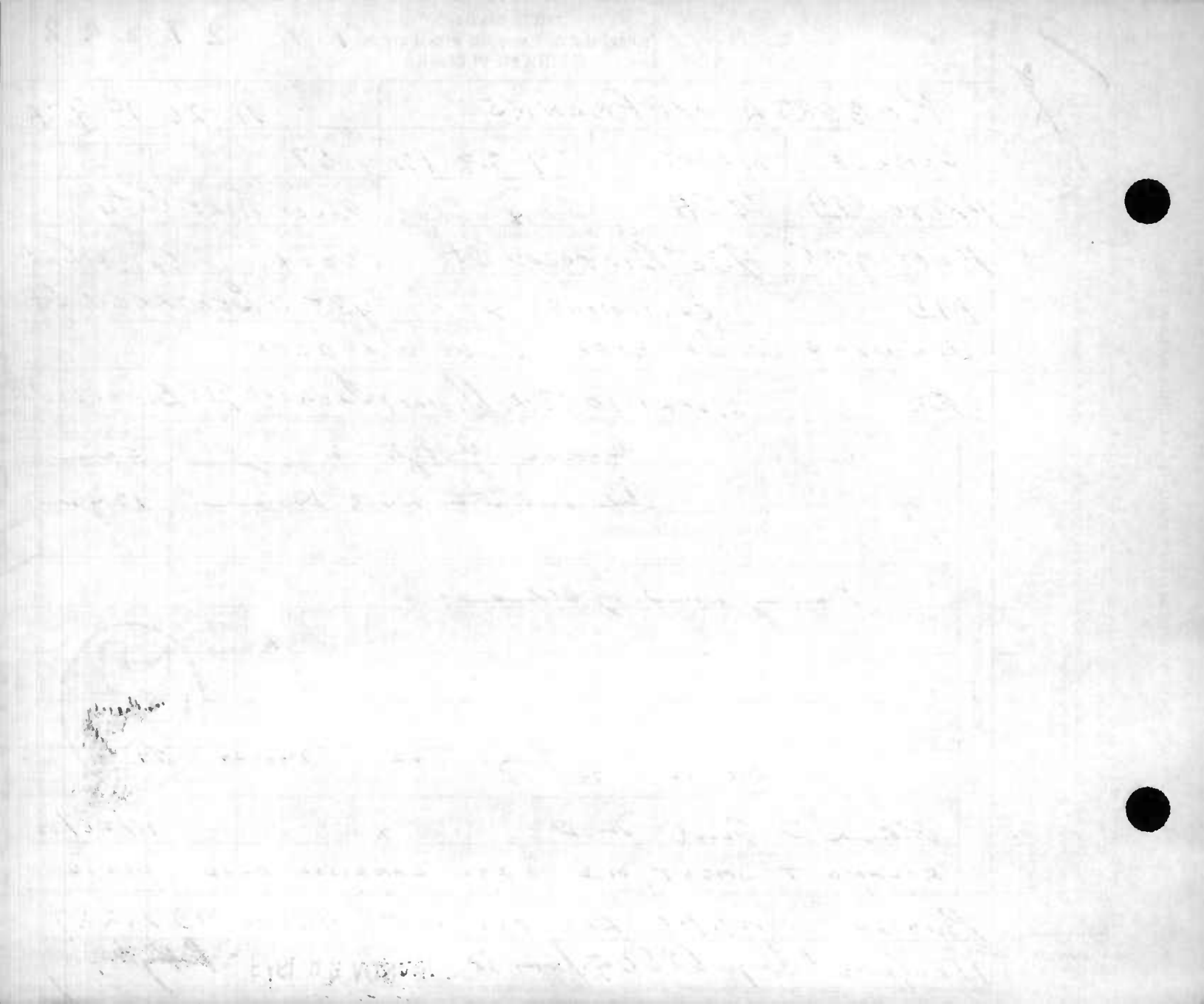
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1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERTA W. FRANKS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>26</b> YEAR <b>79</b> |   |  | 2b. HOUR<br><b>9<sup>AM</sup></b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>28</b> YEAR <b>12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF KNOWN SUCH FACILITY, AND STREET ADDRESS)<br><b>935 BENTON ST</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COOK</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Spice Shop</b>  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. STREET ADDRESS<br><b>935 N BENTON ST</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>HOWARD</b> MIDDLE <b>W.</b> LAST <b>JOHNSON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ELVA</b> MIDDLE <b>W.</b> LAST <b>WOODSON</b>  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-24-1073-A</b>  |   | 17. INFORMANT<br>NAME <b>HOWARD JOHNSON</b> ADDRESS <b>935 BENTON ST</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>17 years</b>  |  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 min.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Draining wound of Abdomen</b>   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>July 1962</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Draining wound of Abdomen</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1962</b> to <b>Nov 26</b> , 19 <b>79</b> , that (I) (we) last<br>saw the deceased alive on <b>Oct 12</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Roland T. Smoot, M.D.</b>   |  |   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/26/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROLAND T. SMOOT, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>2300 GARRISON BLVD 21216</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(Specify)   |  | 23b. DATE<br><b>12/1/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arboretum Ym PR</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD 21227</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Thompson &amp; Hughes 6365 91st St</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

MEDICAL CERTIFICATION





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

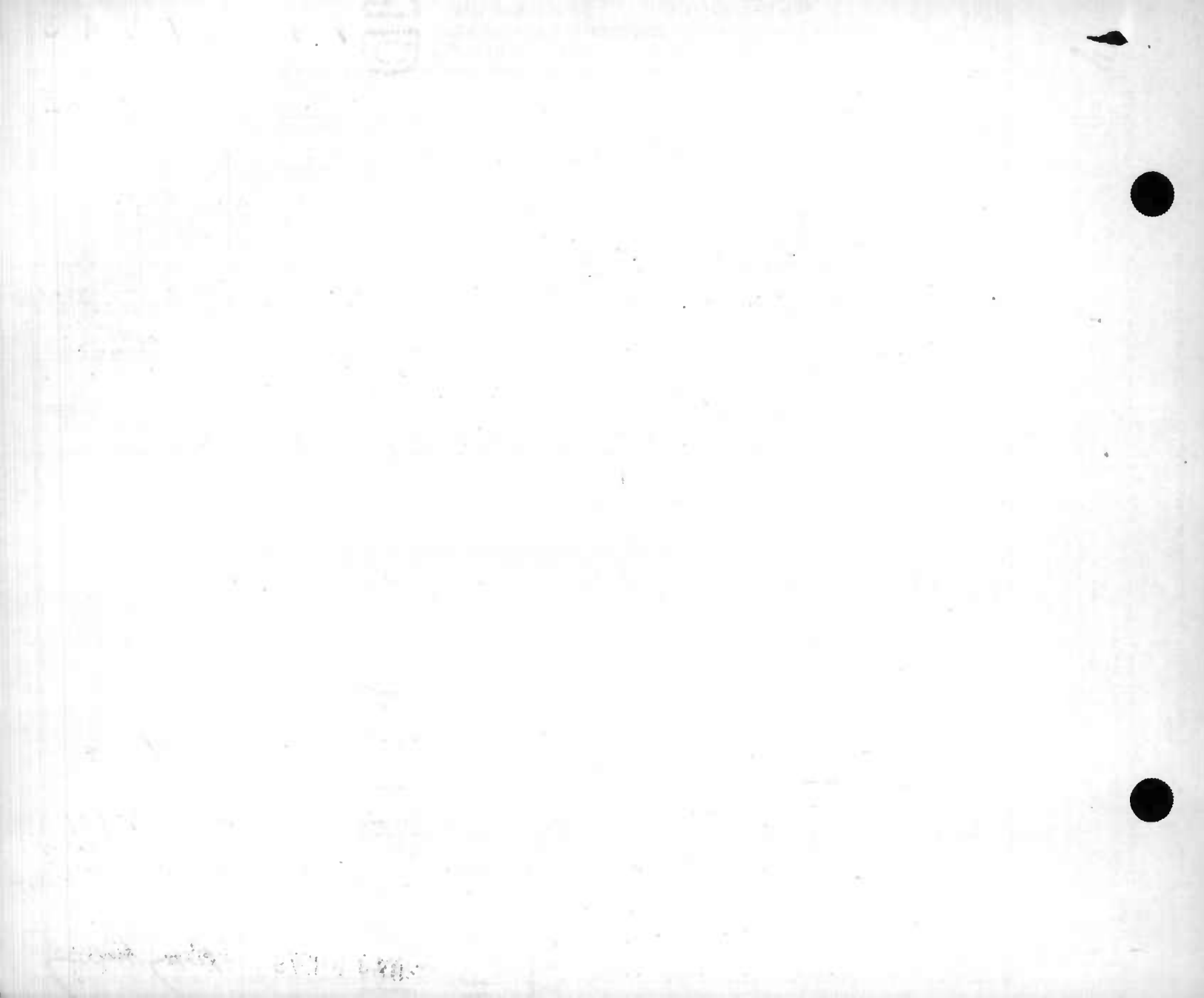
|   |  |  |   |   |                              |  |  |
|---|--|--|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ESTHER FREEDMAN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 12, 1979</b> |   | 2b. HOUR<br><b>2:00 P.M.</b> |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 30 1895</b>   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINTAVE HEBREW GERIATRIC CENTER + HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 13a. CITY OR TOWN<br><b>HARRISBURG</b>  |  | 13b. COUNTY<br><b>DAUPHIN</b>  |   | 13c. CITY OR TOWN<br><b>HARRISBURG</b>  |                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS COHEN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH KANTOR COHEN</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |                              | 16b. SOCIAL SECURITY NO.<br><b>172-01-4176</b>   |  |
| 17. INFORMANT<br><b>IRVIN KRAMER</b>  |  | 18. ADDRESS<br><b>511 SAMOSET RD. RANDALLSTOWN, MD 21133</b>   |   | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>DIABETES MELLITUS, ASYMPTOMATIC, DECUBITI</b>   |  |  |   |   |                              |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9/20 1979</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                              | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              | 21h. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>9/20</b> , 19 <b>79</b> , to <b>11/12</b> , 19 <b>79</b> , that (we) last saw the deceased alive on <b>11/12</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. |  |  |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>Estrelita O. Ku</b>  |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |                              | 22c. DATE SIGNED<br><b>11/12/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ESTRELITA O. KU</b>   |  | 22e. ADDRESS<br><b>LEVINTAVE HEBREW GERIATRIC HOSPITAL</b>   |   | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |                              | 23b. DATE<br><b>NOV 14 1979</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHISUK EMUNA</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HARRISBURG PA.</b>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1979</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |  | 25c. REGISTRAR'S NAME<br><b>Anthony McCreedy</b>   |   | 25d. REGISTRAR'S ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |                              | 25e. REGISTRAR'S PHONE NO.<br><b>777-1111</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



4

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9  
CERTIFICATE OF DEATH

NE 7 9 2 7 3 4 4

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|---|--|---|--|-----------------------------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH   |  | MONTH   |  | DAY   |  | YEAR                              |  | 2b. HOUR                                     |  |  |  |
| Juanita   |  | J.   |  | Freeman   |  |  |  | 11  |  | 6   |  | 79  |  |                                   |  |  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |   |  | 7. IF UNDER 1 YEAR  |  |                                   |  | 7b. IF UNDER 24 HRS                          |  |  |  |
| Female  |  | B  |  | 8. MONTH 8 DAY 6 YEAR 30  |  |  |  | 59  |  |   |  | YRS   |  |                                   |  | MONTHS DAYS HOURS MIN.                       |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |   |  |                                   |  |  |  |  |  |
| W. Va.  |  | USA  |  |   |  |  |  |   |  | Baltimore City  |  |   |  |                                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |  |  |
| Balto.  |  | 4047 Edgewood Rd.  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  | 13e. STREET ADDRESS   |  |   |  |                                   |  |  |  |  |  |
| Md.   |  |  |  | Balto.  |  |  |  |   |  | 4047 Edgewood Rd.   |  |   |  |                                   |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                                   |  |  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  |   |  |  |  | FIRST MIDDLE LAST   |  |   |  |   |  |                                   |  |  |  |  |  |
| Raymond Taylor  |  |  |  |   |  |  |  | Glady's Carroll   |  |   |  |   |  |                                   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  |   |  |  |  | 16b. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT   |  |                                   |  | ADDRESS                                      |  |  |  |
| No  |  |  |  |   |  |  |  |   |  |   |  | Alonzo Freeman  |  |                                   |  | 4047 Edgewood Rd.                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY.   |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| IMMEDIATE CAUSE (a) <u>Bronchial Asthma</u>   |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  | <u>since age 6</u>                           |  |  |  |
| 4939 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |  |  |  |  |
| (b) _____   |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |  |  |  |  |
| (c) _____   |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |                                   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |                                   |  |  |  |  |  |
| 22a. I certify that (I) <input checked="" type="checkbox"/> this hospital attended the deceased from <u>12/18</u> , 19 <u>78</u> , to <u>10/5</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>10/2</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |   |  |                                   |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |   |  |  |  | DEGREE <u>For Asthma</u>  |  |   |  | 22c. DATE SIGNED  |  |                                   |  |  |  |  |  |
| <u>Frank F. Furstenberg MD</u>  |  |  |  |   |  |  |  | MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | <u>11/8/79</u>  |  |                                   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |  |  |  | 22e. ADDRESS  |  |   |  |   |  |                                   |  |  |  |  |  |
| <u>Frank F. Furstenberg</u>   |  |  |  |   |  |  |  | <u>6810 Park Heights Ave</u>  |  |   |  |   |  |                                   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                   |  |  |  |  |  |
| <u>Burial</u>   |  |  |  | <u>11/9/79</u>  |  |  |  | <u>Cedar Hill Cem.</u>  |  |   |  | <u>Ann Arundel Co., Md.</u>   |  |                                   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                   |  |  |  |  |  |
| <u>Wm C March F/H</u>   |  |  |  |   |  |  |  | <u>1101 E. North Ave.</u>   |  |   |  | <u>NOV 8 1979</u>   |  |                                   |  |  |  |  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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2755 BP\_\_\_\_\_

THE UNIVERSITY OF CHICAGO

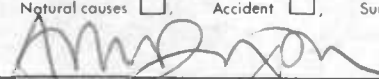
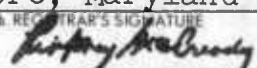


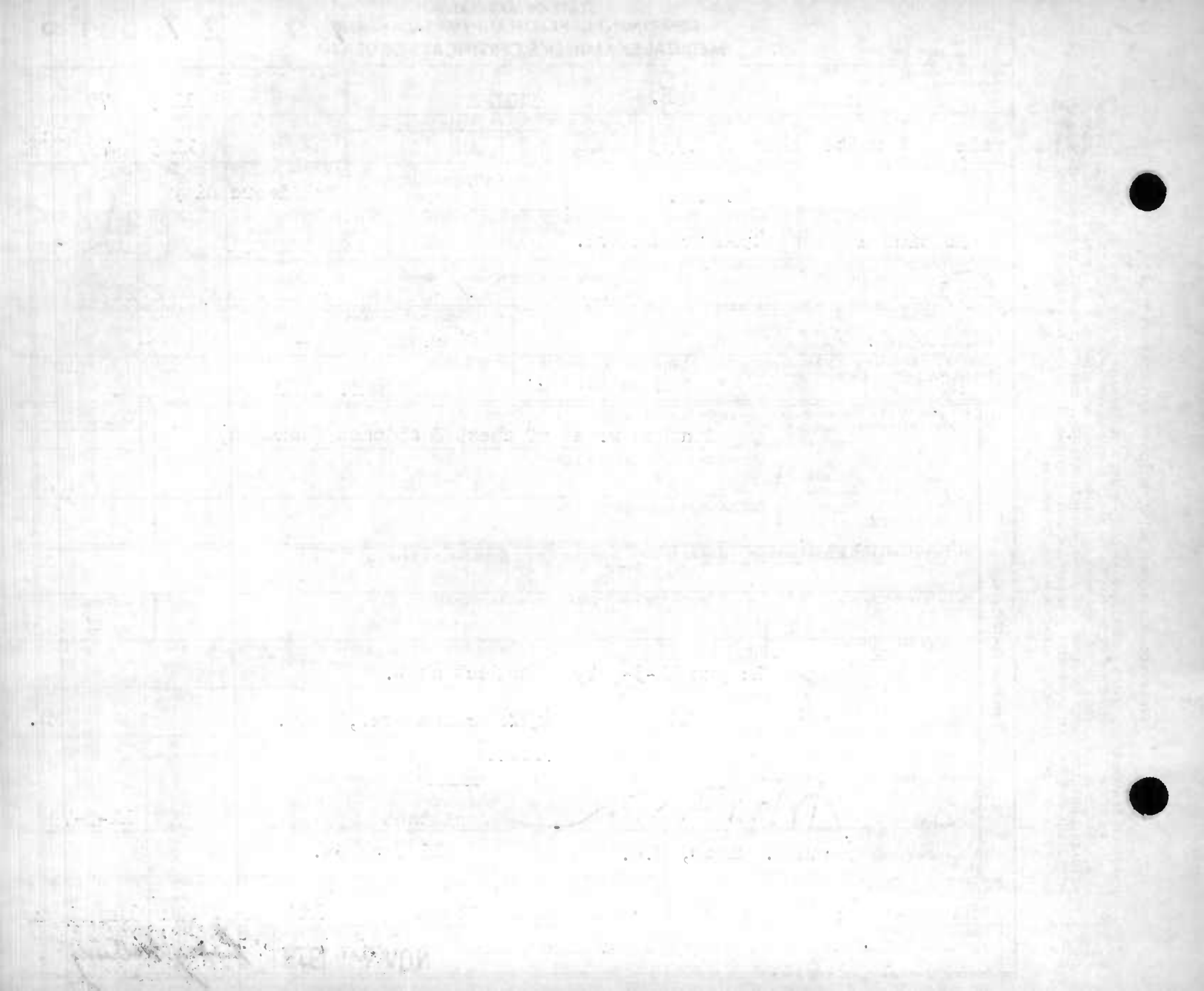
1000 5 1000

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, AND 4 TO THE MEDICAL EXAMINER. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PEBBLE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND  |  |                           |  |   |  |  |  |  |  | 7 9  |  | 2 7 3 4 5   |  |
|--|--|---------------------------|--|---|--|--|--|--|--|--|--|---|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                           |  |   |  |  |  |  |  | REG. NO.   |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                           |  |   |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HAROLD B. FULLER</b>  |  |                           |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 5 1979</b>                      |  | 2b. HOUR MIN. <b>1:15 a.m.</b>                    |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b>      |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 4 1953</b>   |  | 6. AGE (IN YEARS) LAST BIRTHDAY <b>26 YRS.</b>   |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD <b>11 5 1979</b>  |  | 7d. HOUR MIN. <b>1:15 a.m.</b>                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>  |  |                           |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                           |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4502 Erdman Ave.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Drain Mech.</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b> |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                           |  |   |  |  |  |  |  |  |  |   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>-</b>      |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET ADDRESS <b>4460 Clareway 21213</b>   |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Harold J. Fuller</b>  |  |                           |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor - -</b>                                      |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                           |  | 16b. SOCIAL SECURITY NO. <b>214-62-8624</b>   |  | 17. INFORMANT <b>William H. Fuller</b>   |  |  |  | ADDRESS <b>4916 Wilbur Ave.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9650</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of chest &amp; abdomen (handgun)</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____   |  |                           |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                           |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1:05 p.m. 11-5-79</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Subject shot.</b> |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>bldg.</b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4502 Erdman Ave., Balto. Md.</b>                 |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                           |  |   |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE    |  |                           |  | TITLE (SPECIFY) <b>Assistant</b>  |  |  |  | MEDICAL EXAMINER   |  | DATE SIGNED <b>11-5-79</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                           |  | ADDRESS <b>111 Penn St.</b>   |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>7 Nov 79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Schimunek</b>   |  |                           |  | ADDRESS <b>3331 Brehms Lane</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |



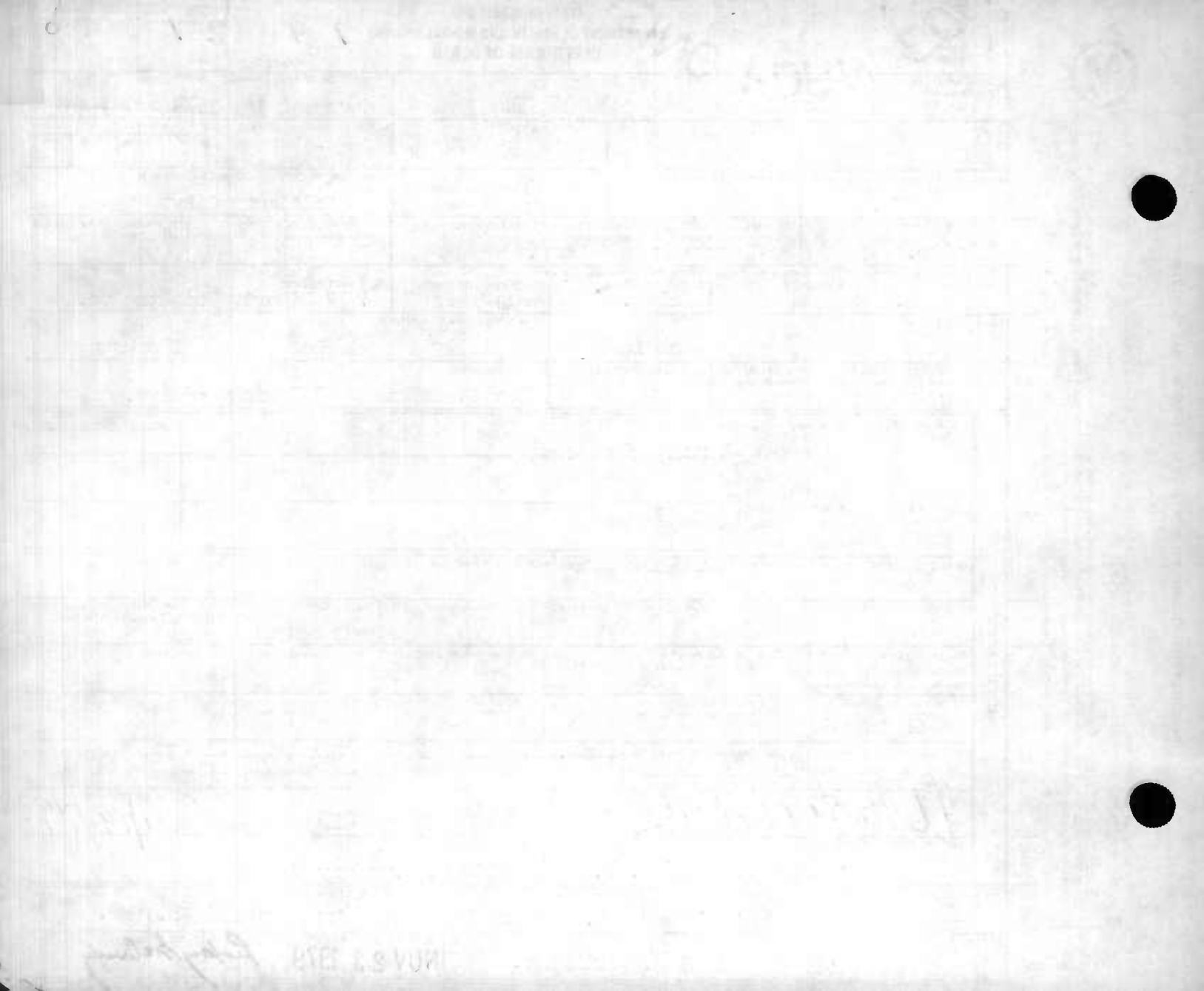


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 7 9 2 7 3 4 6                                |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a DATE OF DEATH MONTH DAY YEAR  |  | 2b HOUR                                      |  |
| Rosetta  |  | GABBIN   |  |   |  |  |  | November 19, 1979  |  | 3:40A M                                      |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 UNDER 1 YEAR MONTHS DAYS   |  | 7 UNDER 24 HRS HOURS MIN.                    |  |
| F  |  | B  |  | 11 18 05  |  | 74 YRS.  |  |  |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |
| Va.  |  | USA  |  |   |  | Baltimore City MD  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY             |  |
| Balto.   |  | Church Homes & Hosp.   |  |   |  |  |  |  |  |  |  |
| 13a STATE  |  | 13b COUNTY   |  | 13c CITY OR TOWN  |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS   |  |  |  |
| Md.  |  |  |  | Balto.  |  |  |  | 4017 Liberty Heights Ave.  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |
| Lee  |  |  |  | Lilly   |  |  |  | Lee Thompson   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS   |  |  |  |  |  |
| No   |  |  |  |   |  | John P. Gabbin   |  | 747 Richwood Ave.  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of pancrea</u>   |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
|  |  | P.M. 19  |  |   |  |  |  |  |  |  |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
|  |  |  |  |   |  |  |  |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from Nov. 7, 1979, to Nov. 19, 1979, that (I) (we) lost saw the deceased alive on Nov. 19, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |  |
| 22b SIGNATURE  |  |  |  | DEGREE  |  |  |  | 22c DATE SIGNED  |  |  |  |
|  |  |  |  |   |  |  |  | 11/19/79   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e ADDRESS   |  |  |  |  |  |  |  |
| Walker Impagliatelli M. D.   |  |  |  | 100 N. Broadway   |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| Burial   |  | 11/23/79   |  | Mt. Calvary Cem.  |  | Anne Arundel Co., Md.  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME   |  |  |  | 24b ADDRESS   |  |  |  | 25a DATE REC'D BY REGISTRAR  |  | 25b REGISTRAR'S SIGNATURE                    |  |
| Wm C March F/H   |  |  |  | 1101 E. North Ave.  |  |  |  | NOV 23 1979  |  | Dorothy McCreedy                             |  |



NOV 19 1957



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |                        |   |  |   |  |   |  |  |  |   |                    |   |                     |                         |
|--|------------------------|---|--|---|--|---|--|--|--|---|--------------------|---|---------------------|-------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                        | FIRST<br><b>CHARLES</b>   |  | MIDDLE  |  | LAST<br><b>GABRIEL</b>  |  | 2a. DATE KNOWN<br>OF DEATH   |  | <input checked="" type="checkbox"/> ESTI-<br>MATED                  | MONTH<br><b>11</b> | DAY<br><b>7</b>   | YEAR<br><b>1979</b> | 2b. HOUR<br><b>8:50</b> |
| 3 SEX<br><b>male</b>   | 4 RACE<br><b>white</b> | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 10, 89</b>                               |  | 6 AGE (IN YEARS<br>LAST BIRTHDAY)<br><b>90 YRS.</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN  |  | 7c. DATE<br>PRONOUNCED<br>DEAD                                      |                    | MONTH<br><b>11</b>  | DAY<br><b>7</b>     | YEAR<br><b>1979</b>     |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>Czech.</b>  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                   |  |  |  |   |                    |   |                     |                         |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br><b>3622 Kenyon Avenue</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>OR MOST OF WORKING LIFE)<br><b>Presser</b>  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br><b>Tailor Shop</b>          |                    |   |                     |                         |
| 13a. STATE<br><b>Maryland</b>  |                        | 13b. CITY OR TOWN<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3622 Kenyon Ave. 21213</b>                               |  |   |                    |   |                     |                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |                        |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b> |  |   |                    |   |                     |                         |
| 16b. SOCIAL SECURITY NO.<br><b>216-07-2064</b>   |                        |   |  | 17. INFORMANT<br><b>Rose Wheeley (daughter)</b>   |  |   |  | ADDRESS<br><b>same address</b>   |  |   |                    |   |                     |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease and</b><br><b>chronic obstructive pulmonary disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |                        |   |  |   |  |   |  |  |  |   |                    |   |                     |                         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                        |   |  |   |  |   |  |  |  |   |                    |   |                     |                         |
| 19a. DATE OF OPERATION   |                        |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |                    | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     |                         |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                        |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)      |  |   |                    |   |                     |                         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                        |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |   |                    |   |                     |                         |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                        |   |  |   |  |   |  |  |  |   |                    |   |                     |                         |
| ACTUAL<br>SIGNATURE<br><i>Margarita A. Korell</i>  |                        |   |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | MEDICAL EXAMINER   |  |   |                    | DATE<br>SIGNED<br><b>11/8/79</b>  |                     |                         |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |                        |   |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |  |  |   |                    |   |                     |                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                        |   |  | 23b. DATE<br><b>10 Nov 79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bohemian National</b>                                  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |                    |   |                     |                         |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Schimunek</b>   |                        |   |  | ADDRESS<br><b>3331 Brehms</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1979</b>                                |  |   |                    | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                    |                     |                         |
| Funeral Home, Inc.   |                        |   |  | Lane, Balto. Md.  |  |   |  |  |  |   |                    |   |                     |                         |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEARLY PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES.  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



2000-0000-0000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |  |   |   |   |  |
|--|--|---|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Bessie Riddell</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 16 1979</b>         |   |   | 2b. HOUR<br><b>7:23A M</b>   |   |   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 2, 1898</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br><b>Md</b>  |  |   | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2211 W. Rogers Avenue</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Riddell</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bettie Whitlock</b>   |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>214 18 9299A</b>                        |   | 17. INFORMANT ADDRESS<br><b>The Wesley Home 2211 W. Rogers Avenue 21209</b> |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST.<br>(c) <b>Diabetes Mellitus</b> |  |   |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 hours</b><br><br><b>years</b><br><br><b>years</b>                     |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |   |   |   |  |
| 22a. I certify that (I) (we) <del>XXXXXX</del> attended the deceased from <b>February</b> 19 <b>79</b> , to <b>November 16</b> 19 <b>79</b> , that (I) <del>XX</del> last saw the deceased alive on <b>November 16</b> 19 <b>79</b> , and that in (my) <del>XX</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>XX</del> (did) <del>XX</del> view the body after death.  |  |   |  |   |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Robert E. Roby, Jr., M.D.</b>   |  |   |  |   |   | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>11-16-79</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert E. Roby, Jr., M.D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                               |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/19/ 79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balto. Md</b>            |   |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Burgee Funeral Home 3631 Falls Road 21211</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1979</b>                                |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |



NOV 18 1954  
The Wesley Center  
2311 W. Rogers Avenue  
Baltimore, Md.  
21201

Diabetes Mellitus  
Arteriosclerotic Cardiovascular Disease  
Acute Myocardial Infarction

Robert E. Kohn, Jr., M.D.  
c/o Maryland General Hospital  
11-16-79  
November 16, 1979  
November 16, 1979

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |   |   |   |  |  |
|---|--|--|--|---|---|---|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Agnes C. Gallagher</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 5, 1979</b>         |   |   | 2b. HOUR<br><b>12:15<sup>P</sup></b>  |   |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 1 1897</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2735 Chesterfield Ave.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |   |   |   |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2735 Chesterfield Ave.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William McDonald</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-05-5313</b>                         |   | 17. INFORMANT<br>ADDRESS <b>same address</b><br><b>Barbara Gallagher (dghtr-in-law)</b>   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic Heart Disease</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-17</b> , 19 <b>68</b> , to <b>11-3</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11-3-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Dr. Sebastian Russo</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   | 22e. ADDRESS<br><b>5122 Harford Rd.</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11/8/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat'l</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |  |  |
| 24. FUNERAL HOME<br>NAME<br><b>Szymurek Funeral Home, Inc.</b>  |  |  |  |   | ADDRESS<br><b>3331 Brehms Lane Balto. Md. 21213</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1979</b>              |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |  |  |  |   |   |   |   |  |  |



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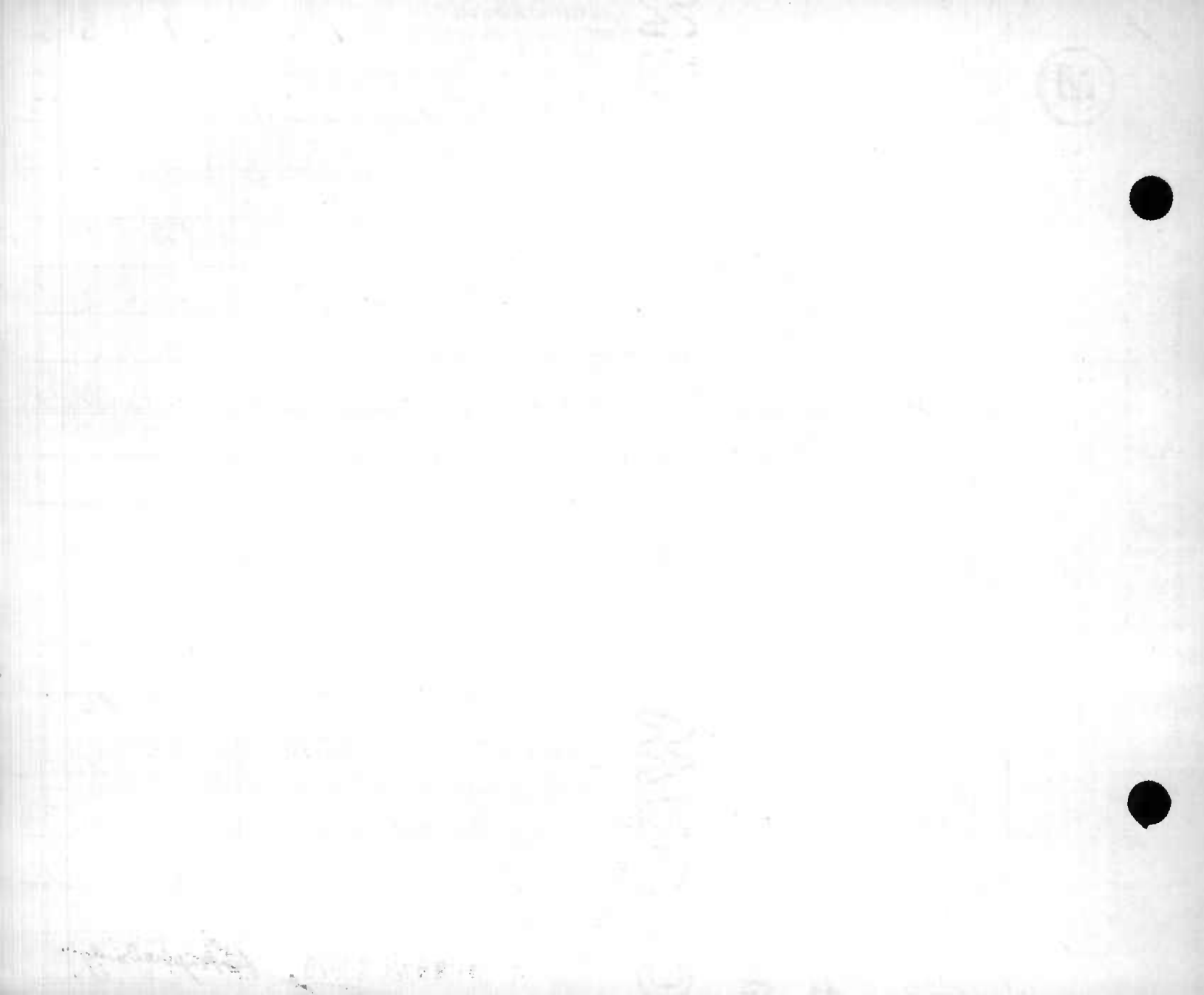


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 7 9 2 7 3 5 0                                |          |                                       |                   |
|---|--|--|--|---|--|--|--|--|--|--|----------|---------------------------------------|-------------------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |  |  |  |  |  |          |                                       |                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Allen   |  | MIDDLE  |  | LAST<br>Gamble   |  | 2a. DATE OF DEATH  |  | MONTH<br>11                                  | DAY<br>9 | YEAR<br>79                            | 2b. HOUR<br>9:57A |
| 3. SEX<br>M   |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH  |  | MONTH<br>6   |  | DAY<br>12  |  | YEAR<br>20                                   |          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore                                    |  |  |  |  |          |                                       |                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |          |                                       |                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE<br>MD   |  | 13c. COUNTY   |  | 13d. CITY OR TOWN<br>BALTO   |  | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13f. STREET ADDRESS<br>815 N. PAYSON ST.     |          |                                       |                   |
| 14. FATHER'S NAME   |  | FIRST<br>Willie  |  | MIDDLE  |  | LAST<br>Gamble   |  | 15. MOTHER'S MAIDEN NAME   |  | FIRST<br>Rosa                                |          | MIDDLE<br>Merris                      |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219287311   |  | 17. INFORMANT<br>Lillie S. Gamble   |  | ADDRESS<br>815 N. Payson St.   |  |  |  |  |          |                                       |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Lung Cancer</u><br>(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>                                |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |                                       |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cerebral metastases</u>  |  |  |  |   |  |  |  |  |  |  |          |                                       |                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |          |                                       |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |  |          |                                       |                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |          |                                       |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>79</u> , to <u>11/9</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |          |                                       |                   |
| 22b. SIGNATURE<br>Sheldon Milner, MD  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br>11/9/79  |  |  |          |                                       |                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sheldon Milner, MD   |  | 22e. ADDRESS<br>730 ASH BURTON ST (21216)  |  |   |  |  |  |  |  |  |          |                                       |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/12/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                         |  |  |  |  |          |                                       |                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H  |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. [Signature]                                      |  |  |  |  |          |                                       |                   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |                                   |   |
|---|--|--|--|---|--|---|--|-----------------------------------|---|
| 1- FOR STATE REGISTRAR  |  |  |  |   | 7 9 2 7 3 5 1<br>CERTIFICATE OF DEATH  |   |  |                                   |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |   | 2a. DATE OF DEATH  |   |  |                                   |   |
| HARRY LEONARD GAMBLE  |  |  |  |   | 11-7-79  |   |  |                                   |   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  | 7b. HOUR                          |   |
| MALE  |  | WHITE  |  | 5-21-05   |  | 74  |  | 805 PM                            |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |   |
| RHODE ISLAND  |  | U.S.A.   |  |   |  | BALTIMORE CITY  |  |                                   |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| BALTIMORE   |  | MERCY HOSPITAL   |  |   |  | PRINTER   |  | NEWSPAPER                         |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13b. INSIDE CITY LIMITS?   |   | 13c. STREET ADDRESS  |                                   |   |
| 13a. STATE  |  |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | APT. 8A<br>8 E. Pleasant St.                                   |                                   |   |
| 14. FATHER'S NAME   |  |  |  |   | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |   |
| WILLIAM GAMBLE  |  |  |  |   | JANE MASON   |   |  |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                   |   |
| NO  |  |  |  |   | 139-05-8749  |   | CECILE D. GAMBLE - APARTMENT 8A<br>8 E. PLEASANT ST. #21202    |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) acute inferior myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF (c) ? |  |  |  |   |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>immediate |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>chronic obstructive pulmonary disease  |  |  |  |   |  |   |  |                                   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |   |
|   |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                                   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                   |   |
|   |  |  |  |   |  |   |  |                                   |   |
| 22a. I certify that (1) this hospital attended the deceased from 11-7-79, to 11-7-79, that (1) (we) lost<br>saw the deceased alive on 11-7-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |                                   |   |
| 22b. SIGNATURE<br>Stuart L. Jacobs MD   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>11-7-79       |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STUART L. JACOBS M.D.  |  |  |  |   | 22e. ADDRESS<br>301 ST. Paul Pl.   |   |  |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                    |  |                                   |   |
| BURIAL  |  | 11/10/79   |  | ST. STANISLAUS  |  | BALTIMORE MD  |  |                                   |   |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  |  |   | 25a. DATE RECD. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                                     |                                   |   |
| George A. Weber & Sons Inc - 705 S. Ann ST. #1231   |  |  |  |   | NOV 9 1979   |   |  |                                   |   |



UNCLASSIFIED

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

7 9 2 7 3 5 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ALONZO, GANTT  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-12-79                  |  | 2b. HOUR<br>M  |
| 3. SEX<br>M   | 4. RACE<br>B  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 - 31 - 1901  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                        |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE, MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD       |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MIDTOWN HOME |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.  |   |  | 13b. COUNTY  | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.<br>213-10-7795  | 17. INFORMANT<br>Mrs. Gantt                                      |  |  |
|   |   | ADDRESS<br>3106 Auchentoroly Terrace   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>General Atherosclerosis, CVA  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/11/79, 19 to 11/12/79, that (I) (we) lost saw the deceased alive on 10/11/79, 19 29, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |   |  |  |  |  |
| 22b. SIGNATURE<br>David M Rosner  |   | DEGREE<br>no   |  | 22c. DATE SIGNED<br>11/12/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David M Rosner   |   | 22e. ADDRESS<br>18 E Eager ST  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE<br>11/19/79  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbundeus Mem. Rk.         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbundeus Wd.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>P. Cuvell   |   | ADDRESS<br>1712-14 W. North Ave  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1979                                   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br>Anthony McBrady  |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
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*[Faint, illegible handwritten text and markings, possibly a signature or date, covering the lower half of the page.]*

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

7 9 2 7 3 5 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |   |  |  |  |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALBERT B. GARY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 18 79</b>                                 |   |  | 2b. HOUR<br><b>3:40 PM</b>   |   |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 7 1902</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1100 Pennsylvania Avenue</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Goble Gabriel Gary</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Vermell Bennett</b>                |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-5110A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Odessa Gary 1100 Pennsylvania Avenue</b>        |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardio respiratory Failure</b><br><b>4439</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Acute Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Renal Failure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b><br><b>5 days</b><br><b>2 weeks</b> |  |  |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>#1 S/P Trans meta tarsal Amputation #2 R Endarterectomy #3 S/P Left Sympholectomy</b>   |  |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>10/14/79, 10/14/79, 10/19/79, 12/30/77</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Peripheral Vascular Disease</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b> P.M.                      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 30</b> , 19 <b>79</b> , to <b>Nov 18</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>11 17</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) see the body after death.  |  |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>R. Damore</b>   |  |  |  |   |  | DEGREE<br><b>Physician</b>   |   | 22c. DATE SIGNED<br><b>11/18/79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. Damore</b>  |  |  |  |   |  | 22e. ADDRESS   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11/24/1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co., Maryland</b>                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 East North Avenue</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1979</b>                            |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. The medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

RECEIVED  
JAN 10 1964

MEMPHIS CITY

THE LOUISIANA HOSPITAL

RECEIVED  
JAN 10 1964



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |   |  |  |   | 7 9 2 7 3 5 4                                |  |  |  |
|--|--|---|---|---|--|---|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | REG. NO.   |   |  |  |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Thomas E. GATTON</b>   |  |   |   |   | 2a. DATE OF DEATH <b>11/9/79</b>   |   |  | 2b. HOUR <b>5:45 AM</b>  |   |  |  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |   | 5. DATE OF BIRTH <b>7-17-88</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. CITY OR TOWN <b>BALTO.</b> 13c. CITY OR TOWN <b>Catonsville</b>  |  |   |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>78 SMITHWOOD AVE</b>   |  |   |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>E.</b> LAST <b>Gatton</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>J.</b> LAST <b>?</b>  |   |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   |   |   | 16b. SOCIAL SECURITY NO. <b>217-05-4451</b>  |   | 17. INFORMANT <b>Baltimore, Md. 21228.</b><br><b>John H. Summersgill-4807 Wilkins Ave.</b> |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>586-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Edema</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Failure</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |   |   |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |   |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>E. Myers</b>  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |  |   | 22c. DATE SIGNED                             |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EVA MYERS</b>  |  |   |   |   | 22e. ADDRESS   |   |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>11/9/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |   |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Starling Funeral Estab.</b><br><b>736 Edmondson Ave.</b><br><b>Catonsville, Md. 21228</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1979</b>   |   |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78





TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |                              |  | 7 9 2 7 3 5 5                                   |     |            |         |
|--|--|---|--|---|--|---|--|------------------------------|--|---|-----|------------|---------|
| FOR<br>1 - STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |                              |  |   |     |            |         |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a DATE OF DEATH             |  | MONTH   | DAY | YEAR       | 2b HOUR |
| Rae  |  |   |  |   |  | Geffen  |  | November 2, 1979             |  |   |     |            | 4:00A   |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR              |  | IF UNDER 24 HRS                                 |     |            |         |
| Female   |  | White   |  | 10 01 1889  |  | 90 YRS  |  | MONTHS                       |  | DAYS  |     | HOURS MIN. |         |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                              |  |   |     | MD.        |         |
| New York   |  | U.S.A.  |  |   |  | Baltimore City  |  |                              |  |   |     |            |         |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |                              |  |   |     |            |         |
| Baltimore City   |  | Maryland General Hospital   |  | Homemaker   |  |   |  |                              |  |   |     |            |         |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a STATE   |  | 13b COUNTY  |  | 13c CITY OR TOWN  |  | 13d INSIDE CITY LIMITS?      |  | 13e STREET ADDRESS                              |     |            |         |
| Maryland   |  | PRINCE  |  | Forestville   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 4317 Forestville Road, 20028 |  |   |     |            |         |
| 14 FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                              |  |   |     |            |         |
| Bernard  |  | Eva   |  | Freedman  |  |   |  |                              |  |   |     |            |         |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO  |  | 17 INFORMANT  |  | ADDRESS   |  |                              |  |   |     |            |         |
| No   |  | 116-18-0679A  |  | Riverside Funeral Home, 310 Coney Island Ave.   |  | Brooklyn, N.Y.  |  |                              |  |   |     |            |         |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |   |  |                              |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |     |            |         |
| IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b>  |  |   |  |   |  |   |  |                              |  |   |     |            |         |
| 486-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |   |  |   |  |                              |  |   |     |            |         |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b>  |  |   |  |   |  |   |  |                              |  |   |     |            |         |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia</b>   |  |   |  |   |  |   |  |                              |  |   |     |            |         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |                              |  |   |     |            |         |
| <b>Diabetes, Pacemaker Malfunction</b>   |  |   |  |   |  |   |  |                              |  |   |     |            |         |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?    |  |                              |  |   |     |            |         |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                              |  |   |     |            |         |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |                              |  |   |     |            |         |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |                              |  |   |     |            |         |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 1, 1979</b> , to <b>November 2, 1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 2, 1979</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |                              |  |   |     |            |         |
| 22b SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c DATE SIGNED   |  |                              |  |   |     |            |         |
| Mark Davis   |  |   |  |   |  | 11/2/79   |  |                              |  |   |     |            |         |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e ADDRESS   |  |   |  |   |  |                              |  |   |     |            |         |
| Mark Davis, M.D.   |  | c/o Maryland General Hospital   |  |   |  |   |  |                              |  |   |     |            |         |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                           |  |                              |  |   |     |            |         |
| Removal/Burial   |  | 11-04-79  |  | Washington Cemetery   |  | Brooklyn Kings N.Y.   |  |                              |  |   |     |            |         |
| 24 FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a DATE REC'D. BY REGISTRAR  |  | 25b REGISTRAR'S SIGNATURE   |  |                              |  |   |     |            |         |
| Hubbard Funeral Home, Inc.,  |  | 4107 Wilkens Ave.   |  | NOV 5 1979  |  | [Signature]   |  |                              |  |   |     |            |         |



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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |  |                                   |  |
|--|--|--|--|--|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 7 9 2 7 3 5 6  |   |  |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH  |   |  |                                   |  |
| THOMAS F. Geisler Sr.  |  |  |  |  | 11-18-79   |   |  |                                   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  | 7b. HOUR                          |  |
| male   |  | Cauc.  |  | 11-27-12   |  | 66 YRS.   |  | 1:55 AM                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |  |
| Baltimore  |  | U.S.A.   |  |  |  | Baltimore City MD.  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore  |  | Mercy Hospital, Inc.   |  |  |  | Well Driller  |  |                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS  |                                   |  |
| 13a. STATE Maryland  |  |  |  |  | 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. 1227 Battery Ave. 327 E. Sittings St. Balto. Md.          |                                   |  |
| 14. FATHER'S NAME (FIRST, MIDDLE, LAST)  |  |  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST)                           |   |  |                                   |  |
| George Oliver Geisler Smith  |  |  |  |  | Mary White Good  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                   |  |
| No   |  |  |  |  | 233-26-0948  |   | Mary Novak, 1227 Battery Ave. Balto. Md                        |                                   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.   |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>respiratory arrest</u>  |  |  |  |  |  |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>emphysema</u>  |  |  |  |  |  |   |  |                                   | years  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |                                   |  |
|  |  | P.M. 19  |  |  |  |   |  |                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                   |  |
|  |  |  |  |  |  |   |  |                                   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>11-28-79</u> 19 <u>79</u> , to <u>11-18</u> 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>11-18</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                   |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  | 22c. DATE SIGNED   |   |  |                                   |  |
| S. JACOBS MD   |  |  |  |  | 11-18-79   |   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |                                   |  |
| S. JACOBS MD   |  | 301 St. Paul Pl. Batt. Md. 21202   |  |  |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                       |  |                                   |  |
| Burial   |  | Nov. 21, 1979  |  | Cedar Hill Cemetery  |  | Baltimore, Maryland   |  |                                   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE                                    |  |                                   |  |
| McGully Funeral Home, 130 E. Port Ave. Balto. Md.  |  | NOV 19 1979  |  |  |  | [Signature]   |  |                                   |  |

RECEIVED  
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NOT FOR  
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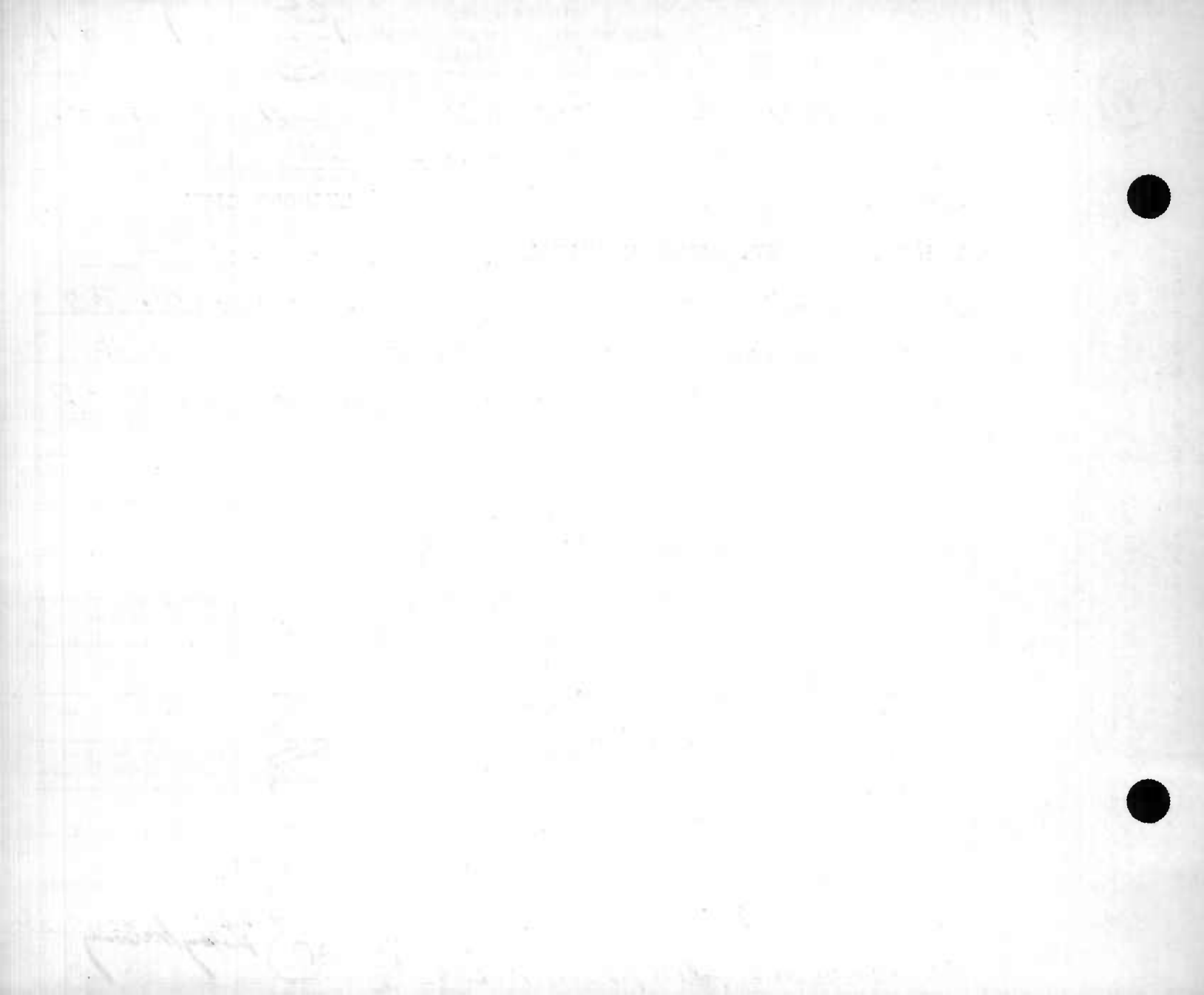
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(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 9 2 7 3 5 7  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR <u>Elizabeth C</u>  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><u>Elizabeth C Gemmill</u>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>11 4 79</u>   |  | 2b. HOUR<br><u>345</u> M  |  |
| 3. SEX<br><u>F</u>   |  | 4. RACE<br><u>W</u>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>5 15 1952</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><u>27</u> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>WASH D.C.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>ST. AGNES HOSPITAL</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>PSYCHOLOGIST</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>-</u>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><u>MD</u>  |  | 13b. COUNTY<br><u>BALTO</u>   |  | 13c. CITY OR TOWN<br><u>BALTO</u>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>JAMES EDWARD CASEY</u>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>BOZORTH SCAIFE</u>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>NO</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>431-</u>   |  |
| 17. INFORMANT ADDRESS<br><u>WAYNE GEMMILL ORPINGTON RD</u>   |  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>431-</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Brain death</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>Massive intracerebral hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 26</u> 19 <u>79</u> to <u>Nov. 4</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 4</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <u>W. L. Duond</u>  |  |   |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Zalduondo</u>  |  |   |  | 22e. ADDRESS<br><u>ST AGNES HOSPITAL</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>   |  | 23b. DATE<br><u>11/9/79</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>LOMBARDY CEM</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>WILMINGTON DELAWARE</u>   |  |
| 24. FUNERAL DIRECTOR NAME<br><u>WEBER FUNERAL HOME</u>   |  | ADDRESS<br><u>EDMONDSON AVE</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 8 1979</u>   |  | 25b. SIGNATURE<br><u>W. L. Duond</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR  
STATE  
REGISTRAR

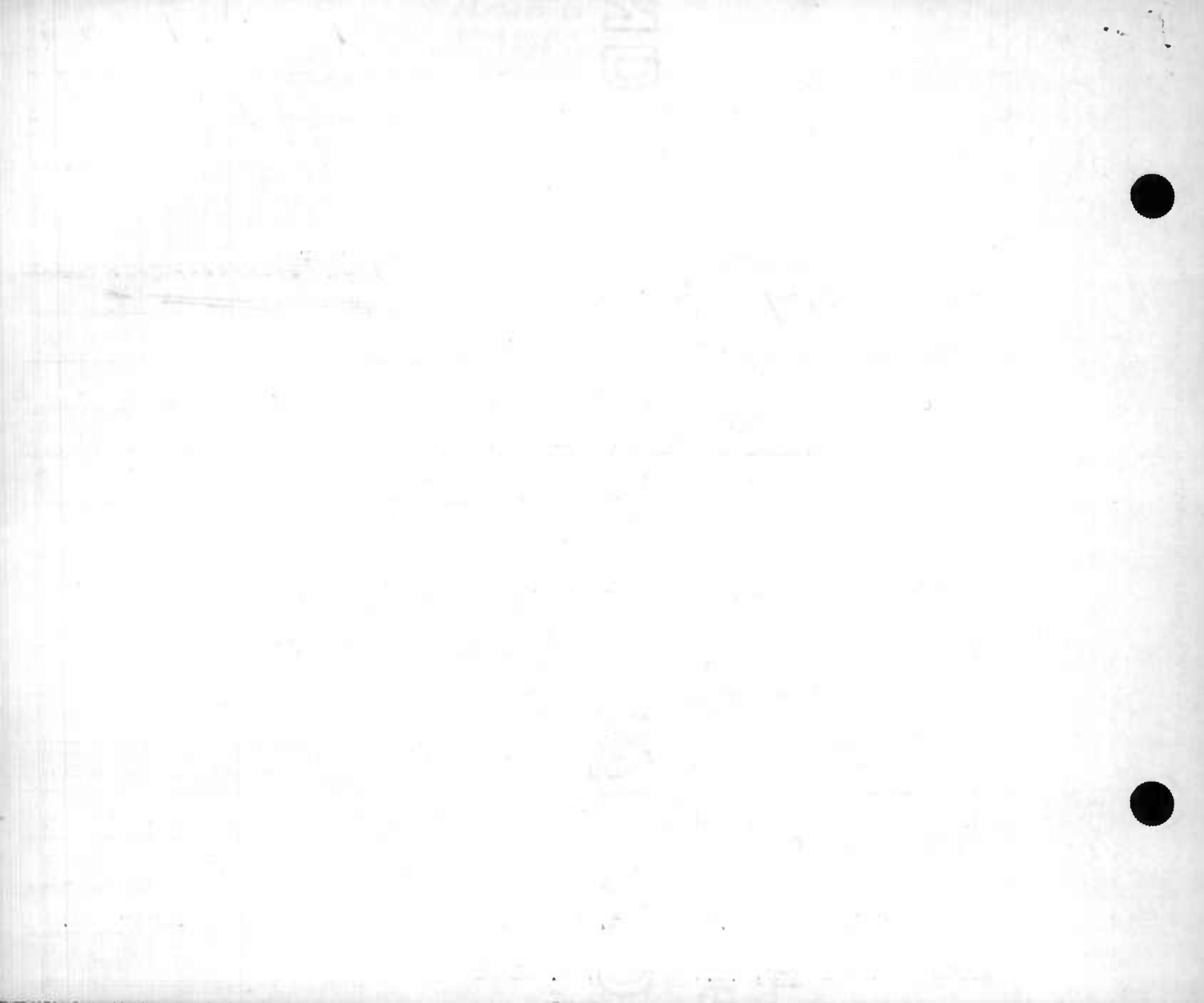
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 3 5 8

REG. NO.

|  |  |                      |   |  |  |  |  |   |   |  |  |
|--|--|----------------------|---|--|--|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Callie Gentry</u>   |  |                      | 2a. DATE OF DEATH MONTH DAY YEAR <u>11/30/79</u>  |  |  | 2b. HOUR <u>4:40</u> M   |  |   |   |  |  |
| 3. SEX <u>F</u>  |  | 4. RACE <u>White</u> |   | 5. DATE OF BIRTH MONTH DAY YEAR <u>5-31-96</u> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |   | 8. IF UNDER 24 HRS. HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balt. City</u> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH <u>Balt. City</u>  |  |                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Good Samaritan Hospital</u> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Seamstress</u>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD.</u> 13b. CITY <u>Balt.</u> 13c. ETTY OR TOWN <u>Balt.</u>   |  |                      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 13e. STREET ADDRESS <u>1254 CEDARROCK ROAD, BALTIMORE</u>  |  |   | 13f. <u>718 Dunbar Rd</u>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>William Edwards</u>   |  |                      |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Susan Burham</u>   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>  |  |                      | 16b. SOCIAL SECURITY NO. <u>215-18-9301</u>   |  |  | 17. INFORMANT ADDRESS <u>pt. chart/info sheet - unit 500</u>   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |                      |   |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>C.V.A. (Cerebrovascular Accident)</u>   |  |                      |   |  |  |  |  |   |   | <u>2-3 days</u>                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Arteriosclerotic Cardiovascular disease</u>   |  |                      |   |  |  |  |  |   |   |  |  |
| (c) <u>due to, OR AS A CONSEQUENCE OF</u>  |  |                      |   |  |  |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus = ASHD. Previous myocardial infarction</u>  |  |                      |   |  |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>11/30</u>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> to <u>11/30</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/30</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                      |   |  |  |  |  |   |   |  |  |
| 22b. SIGNATURE <u>Felix R. Tan</u> DEGREE  |  |                      |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |   | 22c. DATE SIGNED <u>11/30/79</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FELIX R. TAN, M.D.</u>  |  |                      |   |  |  | 22e. ADDRESS <u>3800 ERDMAN AVE 21213</u>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  |                      | 23b. DATE <u>4 Dec. 1979</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Methodist</u> |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Fountain Green Harford Md.</u> |   |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <u>Tarring Funeral Home, P.A., Aberdeen, Md. 21001</u>   |  |                      |   |  |  | 25a. DATE REC'D. BY REGISTRAR <u>DEC 5 1979</u>  |  |   | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |  |

BP



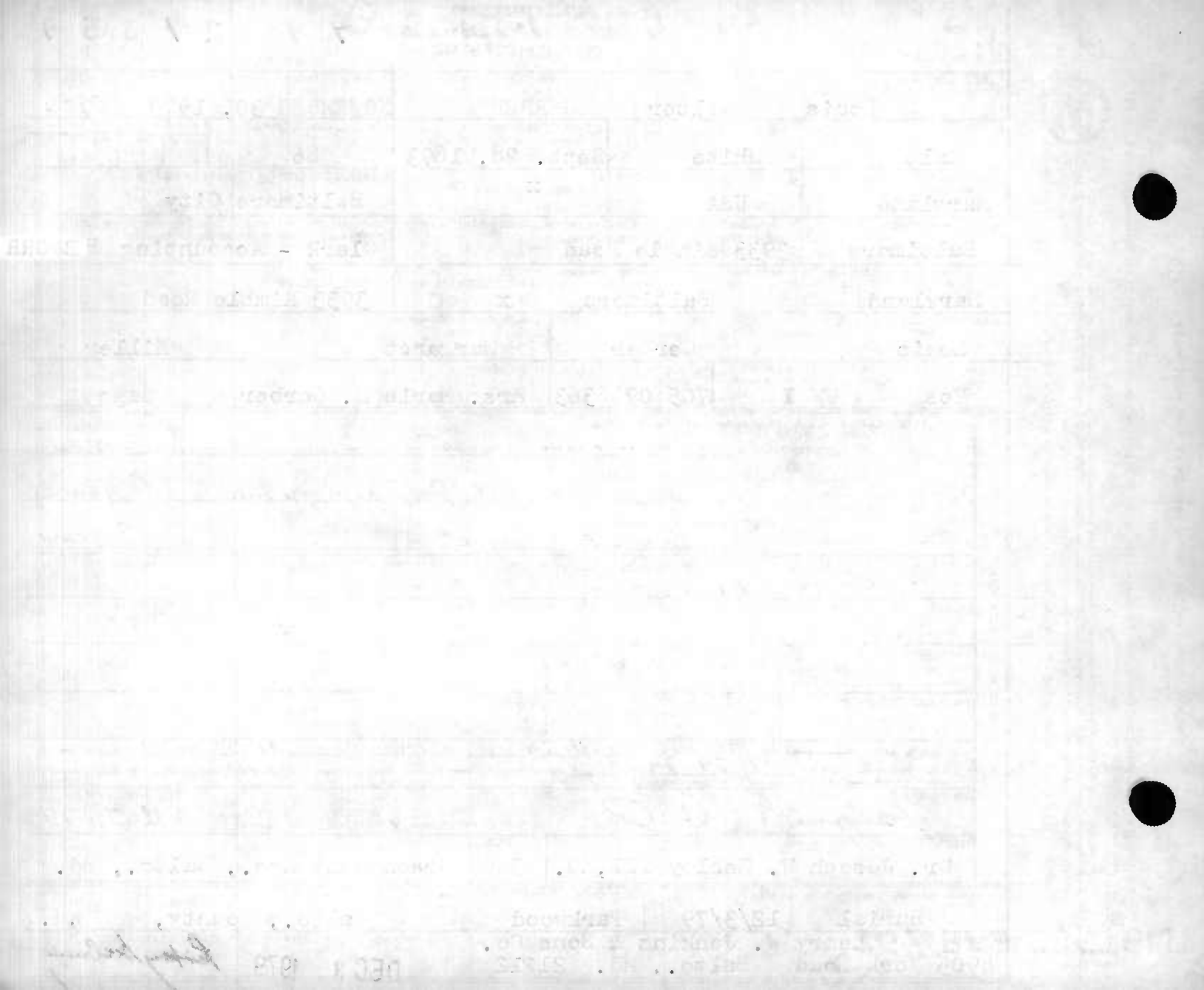


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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 2 7 3 5 9  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  | 2b. HOUR                                     |  |
| Louis  |  | Walter   |  | GERBER   |  |  |  | NOVEMBER 30, 1979  |  | 09 <sup>00</sup> AM                          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS                                    |  | IF UNDER 24 HRS HOURS MIN                    |  |
| Male   |  | White  |  | Sept. 28, 1893   |  | 86 YRS.  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| Maryland   |  | USA  |  |  |  | Baltimore City MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore  |  | 3933 Kimble Road   |  |  |  |  |  | Clerk - Accounting   |  | B&O RR                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13a. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |  |  |
| 13a. STATE   |  |  |  | 13b. COUNTY  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 3933 Kimble Road   |  |  |  |
| Maryland   |  |  |  | Baltimore  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |
| Louis Gerber   |  |  |  | Margaret Miller  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |
| Yes  |  |  |  | WW I   |  | 705 09 6363 Mrs. Marie D. Gerber   |  |  |  | Same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>  |  |  |  |  |  |  |  |  |  | 3 mins                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>492-</u>   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Long Standing COPD - Emphysema</u>   |  |  |  |  |  |  |  |  |  | 5 years                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cigarette abuse</u>  |  |  |  |  |  |  |  |  |  | 50 years                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Possible P. nictal CVA</u>  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>11-29-79</u> to <u>11-30-79</u> , that (I) <u>we</u> lost saw the deceased alive on <u>11-29-79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED                             |  |
| <u>Dr. Joseph W. Zebley III</u>  |  | MD   |  |  |  |  |  |  |  | 12-01-79                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| Dr. Joseph W. Zebley III, MD.  |  |  |  | 3809 Greenmount Ave., Balto., Md.  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| Burial   |  | 12/3/79  |  | Parkwood   |  | Balto., County, Md.  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212   |  |  |  | DEC 3 1979   |  | <u>Henry W. Jenkins</u>  |  |  |  |  |  |



*[Handwritten signature]*

DEC 1 1974

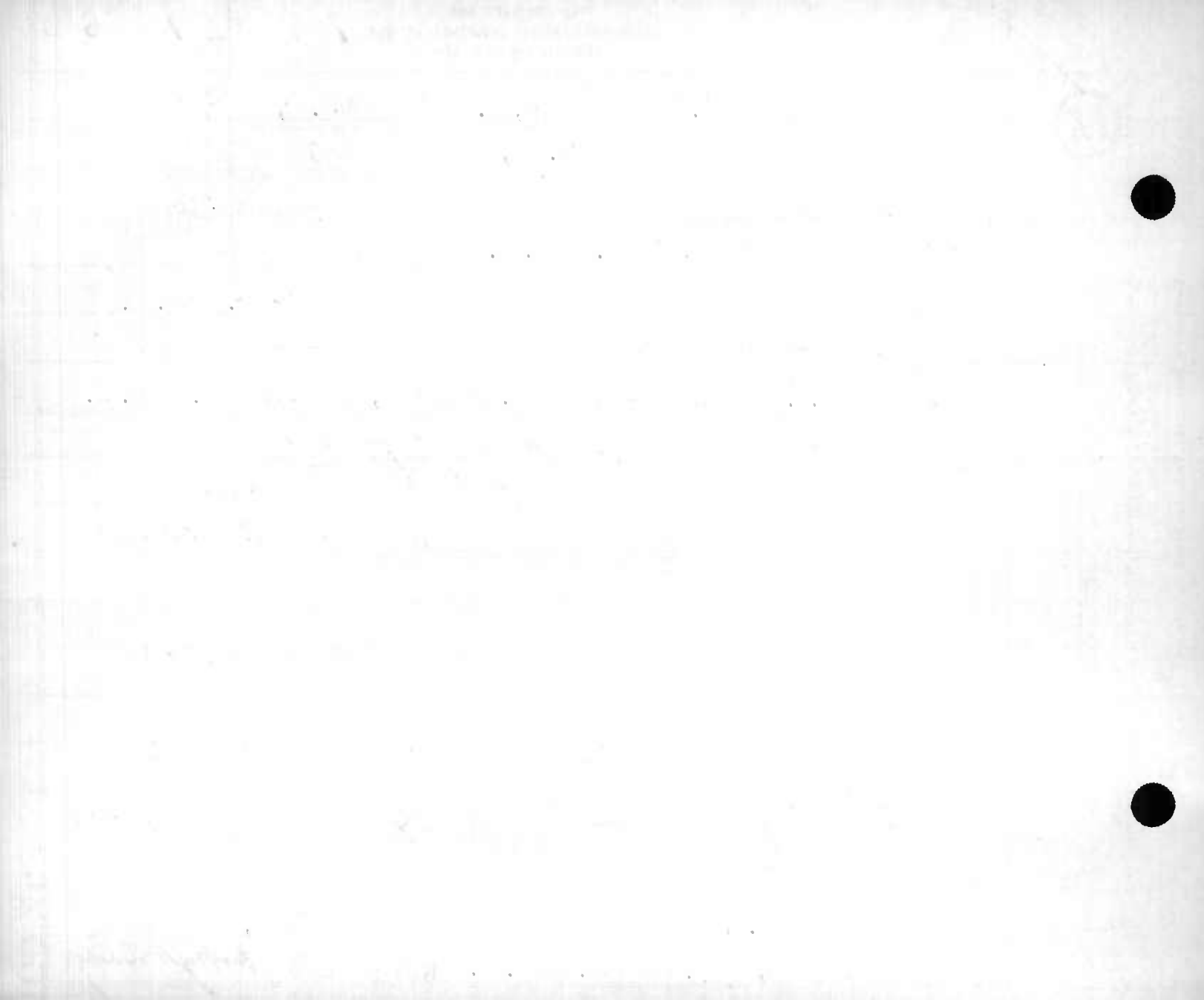
12/1/74  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  | 7 9 2 7 3 6 0   |   |  |  |  |
|--|--|---|--|--|---|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR  |  |   | REG. NO.   |  |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Thomas F. Gerst, Sr.</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Nov. 3, 1979</i>                 |  |   | 2b. HOUR<br>M<br><i>AM</i>  |  |  |  |
| 3 SEX<br><i>Male</i>   |  | 4 RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Jan. 14, 1916</i>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>63</i> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1604 Light St. Balto. Md.</i> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Bakers Helper</i>        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>1604 Light St. Balto. Md.</i>            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Peter ----- Gerst</i>  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Agnes ----- Sindell</i> |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><i>W.W.2</i>  |  | 17 INFORMANT<br>ADDRESS<br><i>Mrs. Mary Gerst, 817 William St. Balto. Md.</i>  |   |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Hypertensive Cardi-</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Vascular Disease</i> |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-4</i> 19 <i>78</i> , to <i>4-3</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>4-3</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   |   | 22c. DATE SIGNED<br><i>11-5-79</i>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>Nov. 7, 1979</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i>                        |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>McGully Funeral Home, 130 E. Front Ave. Balto. Md.</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 5 1979</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
7 9 2 7 3 6 1  
REG. NO.

1- STATE REGISTRAR CATHERINE Cecilia GESSNET CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Anderson, Catherine Cecilia GESSNET

2a. DATE OF DEATH MONTH DAY YEAR  
11 - 16 - 79 2b. HOUR  
1:55 PM

3. SEX FEMALE 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR  
4 29 91 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John A. Packer Med Center 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) HOUSEWIFE 12b. KIND OF BUSINESS OR INDUSTRY College

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Bel Air 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 6 Linwood GARTH

14. FATHER'S NAME FIRST MIDDLE LAST John JOSEPH KERWIN 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Cavanaugh

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 160-20-3666 17. INFORMANT(S) John E Gessner MD ADDRESS 6 Linwood GARTH Bel Air Md, 21014

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Terminal Pulmonary Embolism 24 hrs.  
DUE TO, OR AS A CONSEQUENCE OF (b) Medication Caustic Stomach 17 mos.  
DUE TO, OR AS A CONSEQUENCE OF (c) \_\_\_\_\_

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) \_\_\_\_\_

19a. DATE OF OPERATION \_\_\_\_\_ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED \_\_\_\_\_ 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR \_\_\_\_\_ P.M. 19 \_\_\_\_\_ 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) \_\_\_\_\_

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) \_\_\_\_\_ 21f. LOCATION STREET CITY OR TOWN COUNTY STATE \_\_\_\_\_

22a. I certify that the (this hospital) attended the deceased from 10/25/79 19\_\_\_\_\_, to 11/16/79 19\_\_\_\_\_, that (I) (we) lost saw the deceased alive on 11/15/79 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (do not) view the body after death.)  
22b. SIGNATURE John B. Bronshas MD DEGREE MD 22c. DATE SIGNED 11/16/79  
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wes B. BRONSHAS, M.D. 22e. ADDRESS 22 S. Green St Bel Air MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Nov. 19, 1979 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014

24. FUNERAL DIRECTOR Joseph William Foster ADDRESS W. Broadway & Williams St Bel Air, Maryland 21014 25a. DATE REC'D. BY REGISTRAR NOV 20 1979 25b. REGISTRAR'S SIGNATURE John B. Bronshas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. Some words like "the" and "and" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be not just at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |   |  |  |  |  |
|--|--|--|---|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | 7 9 2 7 3 6 2<br>REG. NO.   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Catherine M. Gibbons   |  |  |   |   | 2a. DATE OF DEATH<br>11-26-79   |  |  | 2b. HOUR<br>7:45 AM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>June 15, 1899   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Lady          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dept. store   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md. Baltimore Dickeyville  |  |  |   |   | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13c. STREET ADDRESS<br>2323 Tucker Lane 21207                          |  |  |
| 14. FATHER'S NAME<br>Louis H. Schaefer   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>Mary K. Kriner  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>16b. SOCIAL SECURITY NO.<br>216-05-4137   |  |  |   |   | 17. INFORMANT<br>Mr. Louis F. Gibbons, Jr. 21207  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary vascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Atherosclerotic cardiovascular disease</u> |  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/26/79</u> to <u>4/26/79</u> , that (I) (we) last saw the deceased alive on <u>4/26/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |   |   | DEGREE  |  | 22c. DATE SIGNED<br><u>4/26/79</u>                                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KYAW NYUNT  |  |  |   |   | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>11/29/1979   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn, Balto. Co. Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Schwab 5151 Balto. Nat'l. Pike   |  |  |   |   | 25a. DATE REC'D BY REGISTRAR<br>DEC 3 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                       |  |  |

BP.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   |   |  |   |  |   |  |  |
|--|--|---|---|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR<br><i>Elena</i>   |  | 7 9 2 7 3 6 3   |   |   |  | REG. NO.  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Clara Gibson</i>   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11/18/79</i>                            |   |  | 2b. HOUR<br><i>10 47 P M</i>                                    |  |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>W</i>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>5/11/18</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>61</i> YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MISS.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTO. CITY</i> MD.              |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>BALTO. CITY HOSP</i> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HSW</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |  |
| 13a. STATE<br><i>MD.</i>   |  |   |   |   | 13b. COUNTY<br><i>BALTO</i>  |   | 13c. CITY OR TOWN<br><i>DUNDALK</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>THOMAS BUTLER</i>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>UNK</i>                       |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>UNK</i>  |   | 17. INFORMANT<br><i>LAWRENCE GIBSON</i>   |  |   | ADDRESS<br><i>ABOVE</i>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>b) <i>Myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>c) _____ |  |   |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/18, 1979</i> to <i>11/18, 1979</i> , that (I) (we) last saw the deceased alive on <i>11/18, 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Adam Black</i>  |  |   |   |   | DEGREE<br><i>MD</i>  |   |  | 22c. DATE SIGNED<br><i>11/18/79</i>                             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Adam Black</i>   |  |   |   |   | 22e. ADDRESS<br><i>Balt. City Hosp.</i>  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  |   | 23b. DATE<br><i>11/12/79</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>OAK LAWN</i>                          |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>BALTO. MD.</i>    |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>J.G. CONNELLY</i>  |  |   |   |   | ADDRESS<br><i>300 MACE</i>   |   |  | 25a. DATE<br><i>NOV 13 1979</i>                                 |  |  |



The following is a list of the  
 names of the persons who  
 were present at the meeting  
 held on the 1st day of  
 January, 1900, at the  
 residence of Mr. J. H.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                       |  |  |  |   |  |  |  | REG. NO. 27364  |  |
|---|--|-----------------------|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Robert Gibson</b>   |  |                       |  |  |  |   |  |  |  | 2a. DATE OF DEATH <b>11 9 19 79</b>   |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH <b>March 22, 1935</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>  |  |                       |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                       |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>crane operator</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co</b>   |  |
| 13a. STATE <b>Md</b>  |  | 13b. COUNTY <b>AA</b> |  | 13c. CITY OR TOWN <b>Hanover</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>7101 Forest Avenue</b>  |  |   |  |
| 14. FATHER'S NAME FIRST <b>Holly</b> MIDDLE <b>Gibson</b> LAST  |  |                       |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Mae</b> MIDDLE <b>Goins</b> LAST  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>  |  |                       |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS <b>Joann Gibson same as above</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                       |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                       |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                       |  | 21b. TIME OF INJURY <b>8:40 AM 11/9 1979</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>tractor trailer Driver of pickup truck in collision with</b> |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>roadway</b>   |  | 21f. LOCATION STREET <b>Rt#1, S. Hanover Rd</b> CITY OR TOWN <b>Elkridge</b> COUNTY <b>Howard Co.</b> STATE <b>MD</b>                         |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                       |  |  |  |   |  |  |  | 22b. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b>   |  |                       |  | TITLE (SPECIFY) <b>Assistant</b>   |  |   |  | DATE SIGNED <b>11/10/79</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, MD</b>  |  |                       |  | ADDRESS <b>111 Penn Street, Balto., MD 21201</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                       |  | 23b. DATE <b>Nov. 14, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>McKinney Chapel Cem</b>   |  |  |  | 23d. LOCATION CITY OR TOWN <b>Rogersville</b> COUNTY <b>Tennessee</b> STATE   |  |
| 24. FUNERAL DIRECTOR NAME <b>Donaldson Funeral Home, Laurel, Md</b>   |  |                       |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1979</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>notary McBrady</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |
|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARY GILLANS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-21-79</b><br>HOUR <b>9:05</b> AM                              |  |
| 3 SEX<br><b>F</b>  | 4 RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-20-92</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Md.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MIDTOWN HOME</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a STATE<br><b>Md.</b>  |  | 13b COUNTY<br><b>Balto.</b>  | 13c CITY OR TOWN<br><b>Balto.</b>  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>217-14-0134</b>  | 17 INFORMANT<br>ADDRESS<br><b>Midtown N/ H</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebral Vascular Accident</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>Arteriosclerotic Cardiovascular dy</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>July 10</b> , 19 <b>79</b> , to <b>November 21</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>November 21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.             |  |  |  |  |
| 22b SIGNATURE<br><b>Jack T. Applefield M</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c DATE SIGNED<br><b>11/21/79</b>   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e ADDRESS  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b DATE<br><b>11/26/79</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Ce</b>   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co., Md.</b>                      |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>  |  | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 27 1979</b>  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Calverdy</b>   |

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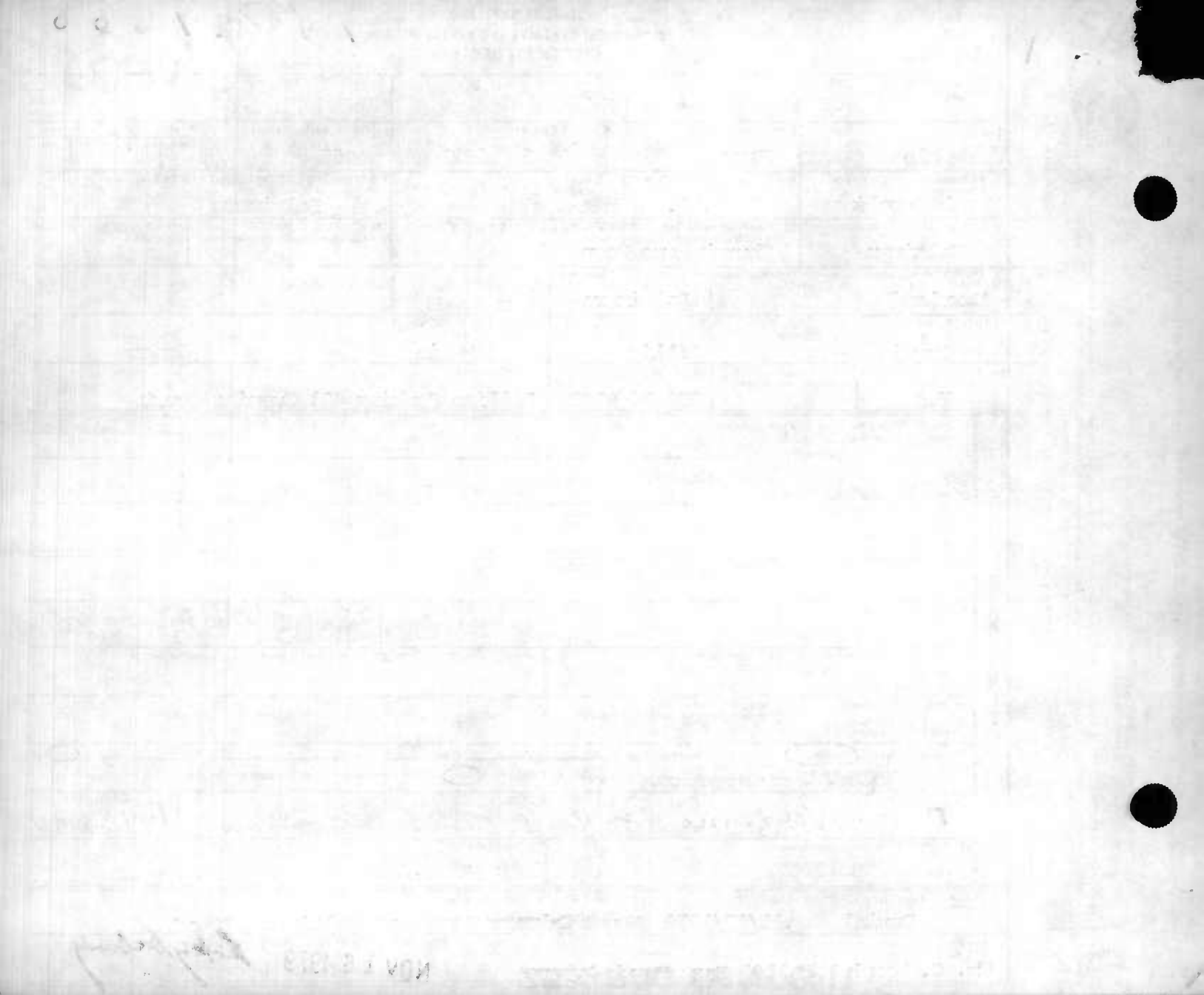
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 only to be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  |  |  |   |  |   |
|---|--|---|---|--|--|--|---|--|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   | REG. NO.  |  |  |  |   |  |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST   |  |  | 2a DATE OF DEATH MONTH DAY YEAR  |   |  | 2b HOUR   |
| JOSEPH GILLIAM XXXXXAM  |  |   |   |  |  | NOVEMBER 13, 1979  |   |  | 8:00 A <sub>M</sub>                             |
| 3 SEX   |  | 4 RACE  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS                                 |   |
| Male  |  | Negro   |   | 9 5 1921   |  | 58 YRS.  |   |  |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  |   |
| North Carolina  |  | U. S. A.  |   |  |  | Baltimore MD.  |   |  |   |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b KIND OF BUSINESS OR INDUSTRY                                 |   |
| Baltimore   |  | Church Home Hospital  |   |  |  |  |   |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |  |   |  |   |
| 13a STATE   |  | 13b COUNTY  |   | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?  |   | 13e STREET ADDRESS   |   |
| Maryland  |  |   |   | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                       |  |   |  |   |
| Curtis Gilliam  |  |   |   |  | Mamie Jones  |  |   |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)     |  | 17 INFORMANT ADDRESS   |  |   |  |   |
| Yes   |  |   | 228-34-9301   |  | Lillian Jenkins 431 Cummins Court  |  |   |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a).<br>436- DUE TO, OR AS A CONSEQUENCE OF<br>CEREBROVASCULAR ACCIDENT<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>LIVER CIRRHOSIS   |  |   |   |  |  |  |   |  |   |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED           |  |  | 20a AUTOPSY?   |   | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |
|   |  |   |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>         |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)      |  |   |  |   |
| 21d PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21e LOCATION<br>STREET CITY OR TOWN COUNTY STATE          |  |  |  |   |  |   |
| 21f WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |   |  |  |  |   |  |   |
| 22a I certify that (I) (this hospital) attended the deceased from 11-1-1979, to 11-13-1979, that (I) (we) last saw the deceased alive on 11-13-1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |   |   |  |  |  |   |  |   |
| 22b SIGNATURE<br>A. F. Nazemi M.D.  |  |   | DEGREE  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c DATE SIGNED<br>11-13-79                                      |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. F. NAZEMI, M.D.  |  |   |   |  | 22e ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD 21231 |  |   |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE |  |   |
| Burial  |  |   | 11/17/1979  |  | Mount Calvary Cemetery   |  | Baltimore, Maryland                       |  |   |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |   |  | 25a DATE REC'D. BY REGISTRAR   |  |   |  |   |
| Wm. C. March F/H 1101 East North Avenue   |  |   |   |  | NOV 16 1979  |  |   |  |   |

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Item 18a 0539 1/18/80

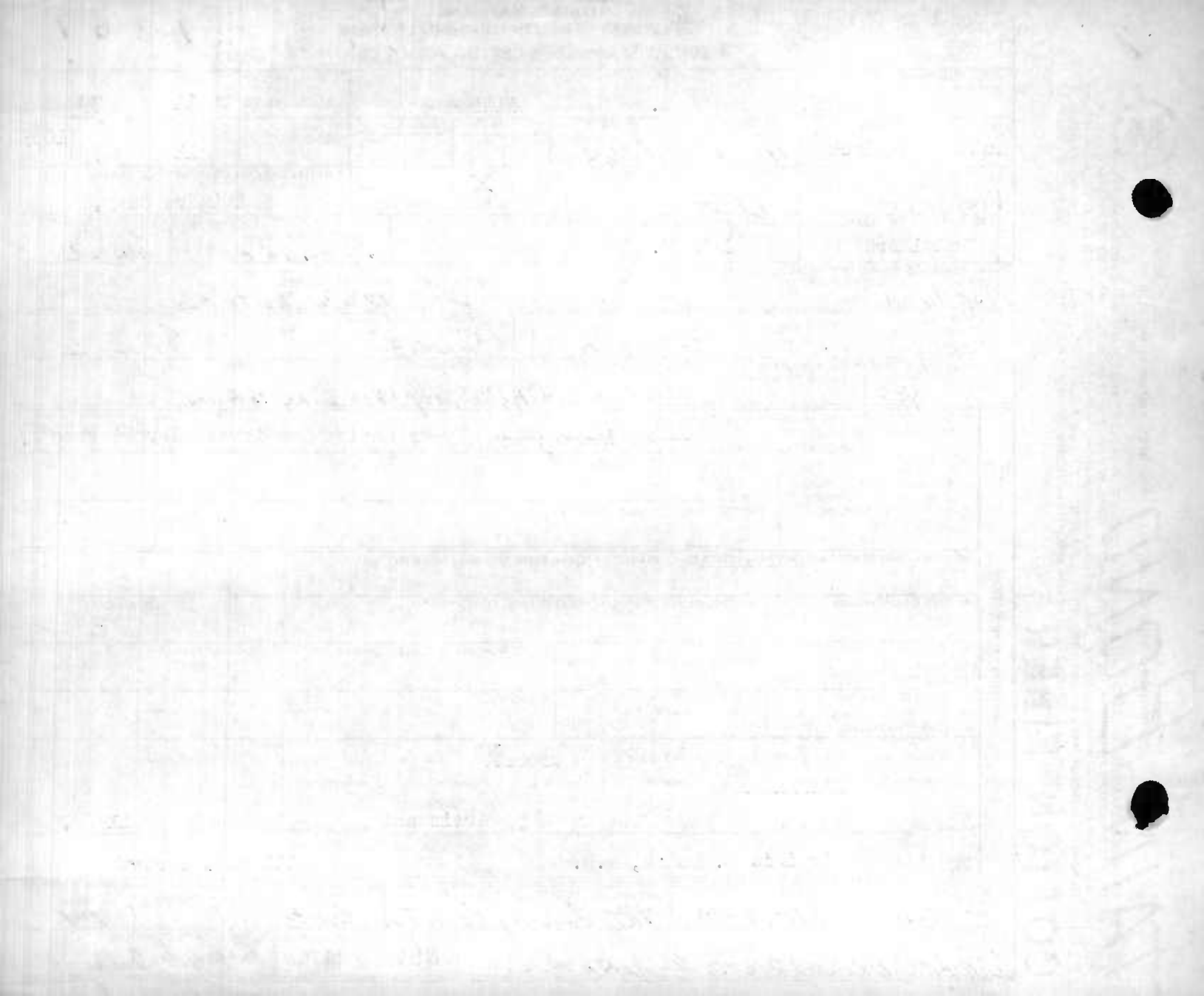
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

27367

|  |  |  |         |  |  |  |  |  |   |  |  |   |            |  |                  |          |   |  |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|---------|--|--|--|--|--|---|--|--|---|------------|--|------------------|----------|---|--|--|--|-----|----------|--|---|--|--|--|----------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST   |  |  | MIDDLE   |  |  | LAST  |  |  | 2a. DATE KNOWN OF DEATH   |            |  |                  | 2b. HOUR |   |  |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| Rudolph  |  |  | C.      |  |  | Gilliam  |  |  | DATE MATED <input checked="" type="checkbox"/> 11 5 19 79 |  |  |   | 11 5 19 79 |  |                  |          | M |  |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  | 4. RACE |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS)   |  |  | IF UNDER 1 YR.  |            |  | IF UNDER 24 HRS. |          |   | 7c. DATE PRONOUNCED DEAD                     |  |  |     | 7d. HOUR |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| Male   |  |  | Black   |  |  | 11 6 1911  |  |  | 68 YRS.   |  |  | MONTHS  |            |  | DAYS             |          |   | HOURS  |  |  | MIN |          |  | 11 6 19 79  |  |  |  | 10:32 AM |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |         |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |            |  |                  |          |   | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| Virginia   |  |  |         |  |  | USA  |  |  |   |  |  |   |            |  |                  |          |   | Baltimore City, MD.                          |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |         |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |            |  |                  |          |   | 12b. KIND OF BUSINESS OR INDUSTRY            |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| Baltimore  |  |  |         |  |  | 1216 W. North Avenue   |  |  |   |  |  | Laborer   |            |  |                  |          |   | None   |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  |  |         |  |  |  |  |  |   |  |  | 13b. COUNTY   |            |  |                  |          |   |  |  |  |     |          |  | 13c. CITY OR TOWN   |  |  |  |          |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?                   |  |  |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |         |  |  |  |  |  |   |  |  | Baltimore   |            |  |                  |          |   |  |  |  |     |          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |  |          |  |  |  |  |  |  |  | 1216 W. North Ave                          |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |         |  |  |  |  |  |   |  |  | 15. MOTHER'S MAIDEN NAME  |            |  |                  |          |   |  |  |  |     |          |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)         |  |  |  |          |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.                   |  |  |  |  |  |  |  |  |  |  |  | 17. INFORMANT       |  |  |  |  |  |  |  |  |  |  |  | ADDRESS           |  |  |  |  |  |  |  |  |  |  |  |
| JERRY  |  |  |         |  |  |  |  |  |   |  |  | CARRIE  |            |  |                  |          |   |  |  |  |     |          |  | YES   |  |  |  |          |  |  |  |  |  |  |  | 225-14-6147A                               |  |  |  |  |  |  |  |  |  |  |  | M. Spady            |  |  |  |  |  |  |  |  |  |  |  | 1218 W. North Ave |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |         |  |  |  |  |  |   |  |  |   |            |  |                  |          |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 4029   |  |  |         |  |  |  |  |  |   |  |  |   |            |  |                  |          |   |  |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |         |  |  |  |  |  |   |  |  |   |            |  |                  |          |   |  |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |         |  |  |  |  |  |   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |            |  |                  |          |   |  |  |  |     |          |  | 20. AUTOPSY?  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |         |  |  |  |  |  |   |  |  |   |            |  |                  |          |   |  |  |  |     |          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |         |  |  |  |  |  |   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |            |  |                  |          |   |  |  |  |     |          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |         |  |  |  |  |  |   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |            |  |                  |          |   |  |  |  |     |          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |         |  |  |  |  |  |   |  |  |   |            |  |                  |          |   |  |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |         |  |  |  |  |  |   |  |  |   |            |  |                  |          |   |  |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u>  |  |  |         |  |  |  |  |  |   |  |  | TITLE (SPECIFY) <u>Assistant</u>  |            |  |                  |          |   |  |  |  |     |          |  | DATE SIGNED <u>11/6/79</u>  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Virginia L. Dolan, M.D.</u>   |  |  |         |  |  |  |  |  |   |  |  | ADDRESS <u>111 Penn Street</u>  |            |  |                  |          |   |  |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |         |  |  |  |  |  |   |  |  | 23b. DATE   |            |  |                  |          |   |  |  |  |     |          |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |          |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |         |  |  |  |  |  |   |  |  | 11-12-79  |            |  |                  |          |   |  |  |  |     |          |  | Mt. Calvary Cemetery  |  |  |  |          |  |  |  |  |  |  |  | Baltimore Md.                              |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  |         |  |  |  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR   |            |  |                  |          |   |  |  |  |     |          |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| William C. Brown   |  |  |         |  |  |  |  |  |   |  |  | NOV 27 1979   |            |  |                  |          |   |  |  |  |     |          |  | Anthony McBrady   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |
| ADDRESS <u>1206 W. North Ave.</u>  |  |  |         |  |  |  |  |  |   |  |  |   |            |  |                  |          |   |  |  |  |     |          |  |   |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |

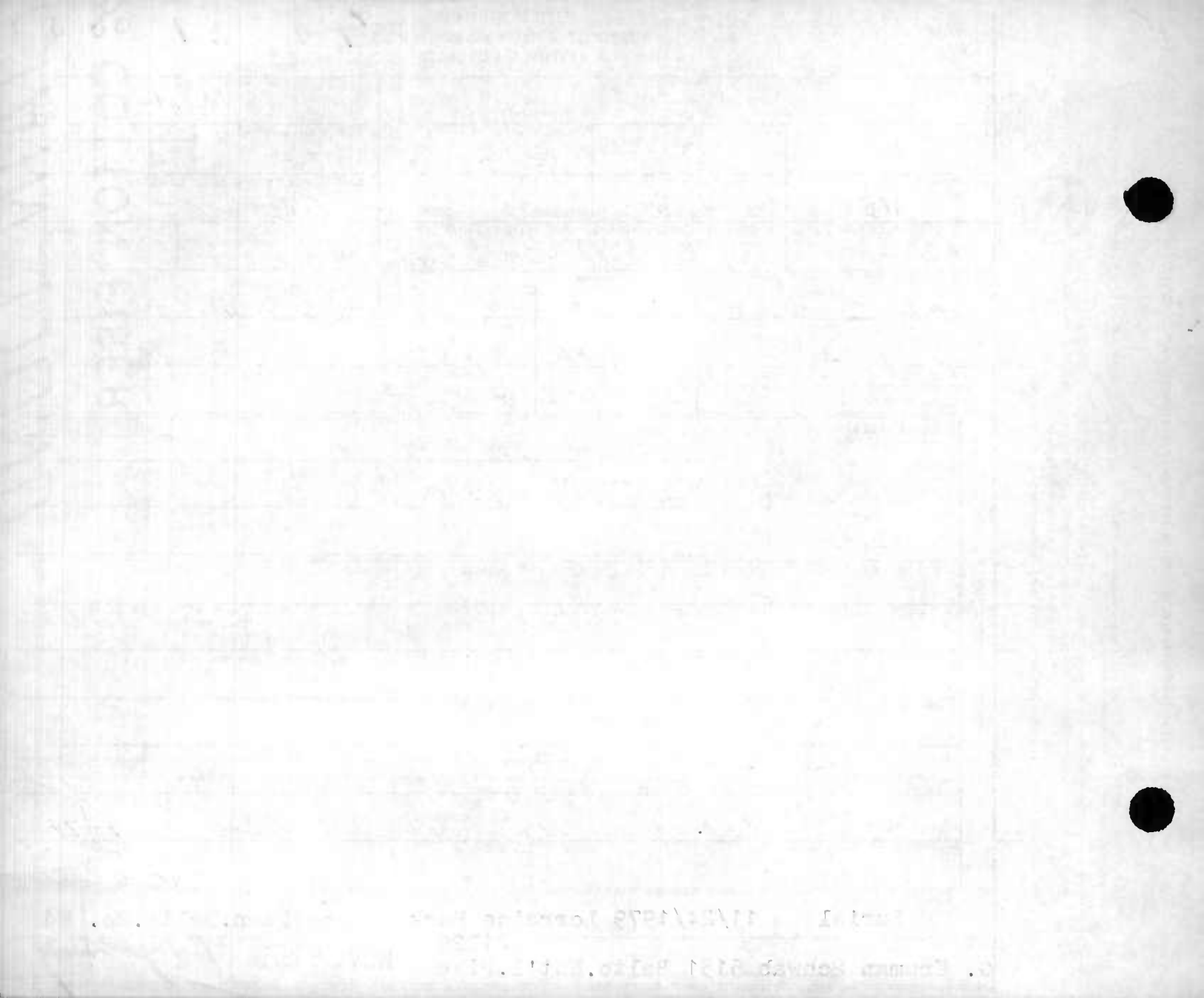
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  |   |  |   | 7 9 2 7 3 6 8<br>CERTIFICATE OF DEATH   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |   | 2a. DATE OF DEATH   |  |   |  |  |
| B Elsie E Gillis   |  |   |  |   | 11 / 20 / 79 9:30 AM  |  |   |  |  |
| 3. SEX<br>F  |  | 4. RACE<br>C  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 26 73   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.   |   | 7b. HOUR   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT CITY MD.                                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALT  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U of Md 22 S. Greene |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE        |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                       |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALT   |  | 13c. CITY OR TOWN<br>BALT   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |   | 436 S. WICKHAM   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH ENSOR   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNIE PATTERSON  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <input checked="" type="checkbox"/>   |  |   |  | 16b. SOCIAL SECURITY NO.<br>220 12 4336   |   | 17. INFORMANT<br>Chart   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR collapse</u><br>1749<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Metastatic CA Breast</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CA Breast</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>9/13/79</u> 19 <u>79</u> , to <u>11/20</u> 19 <u>79</u> , that (1) (we) lost<br>saw the deceased alive on <u>8 AM 11/20/79</u> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.                                    |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>WAF Moore MD   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br>11/20/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MOORE   |  |   |  |   | 22e. ADDRESS<br>U of Md Hosp 725 Greene Bldg BALT   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/24/1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn, Balto. Co. Md                |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Schwab 5151 Balto. Nat'l. Pike   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>21229<br>NOV 26 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. Brady |  |  |



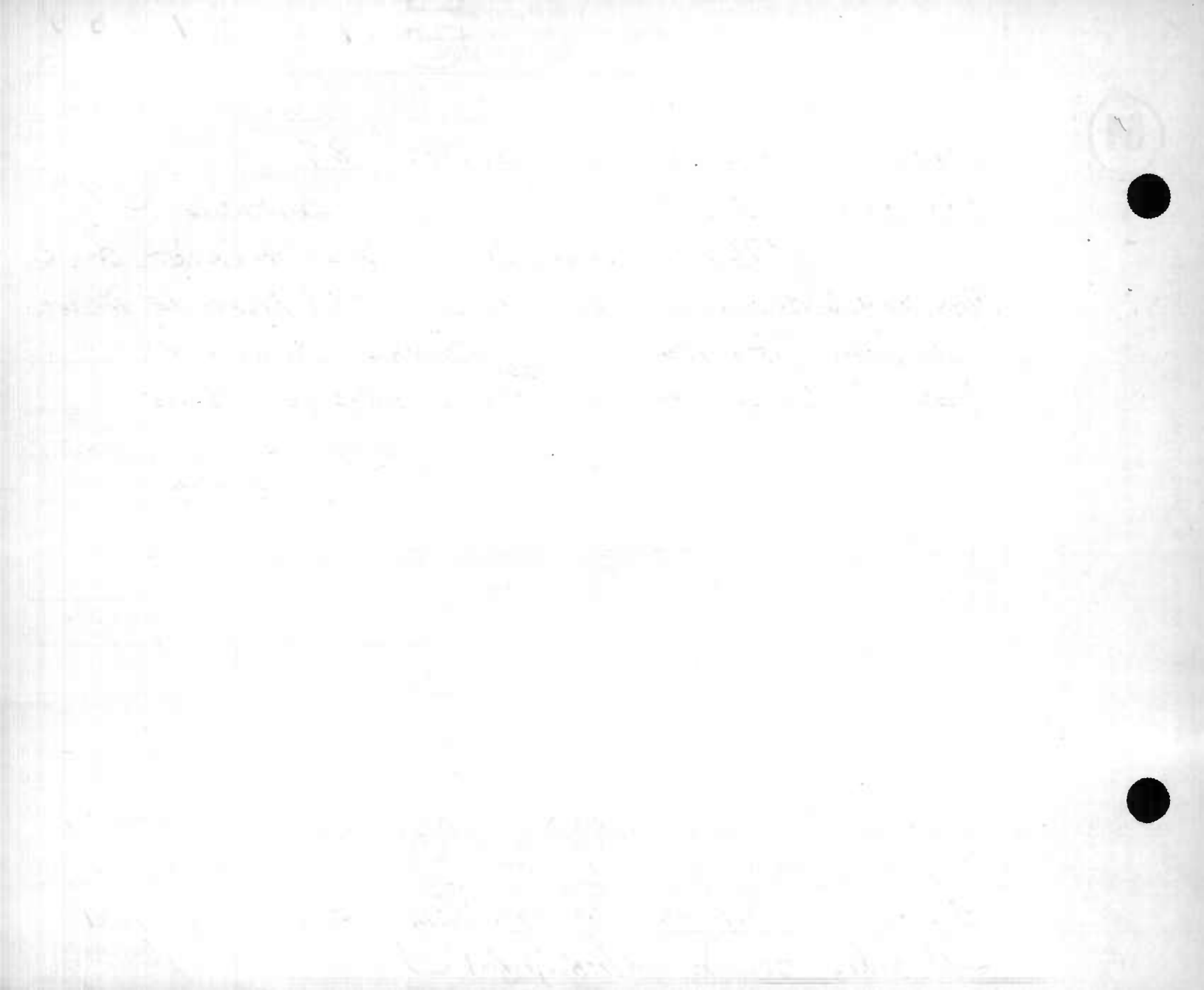
BP

DHMH-16 20M  
(VRA 15, 4) 7/78FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROLLIE DOWNING GILLISS, SR.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>November 18, 1979</b> |  |  | 2b. HOUR<br><b>3 A. M.</b>  |  |  |   |  |  |   |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>MAR 25, 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS<br>HOURS MIN.   |  |   |  |  |  |  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                 |  |  |   |  |  |   |  |  |  |  |  |
| 11. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1709 Ingram Rd.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUST OFFICER Ret Bank</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>Wicomico</b>                               |  |  | 13c. CITY OR TOWN<br><b>Salisbury</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>908 RIVERSIDE DRIVE</b> |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Gilliss</b>   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH ROBINSON</b>                            |  |  |   |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI 214-10-8090</b>                 |  |  |   |  |  | 16c. MARITAL STATUS<br><b>Single</b>              |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>411 - Congestive Heart Failure, Acute</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Acute and Chronic Coronary Insuff.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 wks. 1 year</b> |  |   |  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Cerebrovascular Disease</b>  |  |   |  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1, 1979</b> to <b>Nov 18, 1979</b> , that (I) (we) last saw the deceased alive on <b>Nov 15, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>William P. Benson, Jr. M.D.</b>   |  |   |  |  |  |   |  | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>11-19-79</b>  |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM P. BENSON</b>  |  |   |  |  |  |   |  | 22e. ADDRESS<br><b>3506 N. CALVERT, BALTIMORE, MD.</b>                               |   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   |  | 23b. DATE<br><b>11/20/1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARSONS CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Salisbury, Md.</b>                  |   |  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hill Baker-Bounds</b>   |  |   |  |  |  | ADDRESS<br><b>Salisbury Md</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1979</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 79 27370<br>REG. NO.  |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH JOHN GIORGILLI</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>30</b> YEAR <b>79</b>   |  |   |  | 2b. HOUR<br><b>10:25pm</b>  |  |   |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>21</b> YEAR <b>22</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b>                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD                                |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC BALTIMORE, MARYLAND 21218</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>218 E. PRESTON St.</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>BIAGGIO</b> MIDDLE <b>GIORGILLI</b> LAST <b>GIORGILLI</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>SERAFINA</b> MIDDLE <b>DIBONA</b>  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. (IF YES, GIVE WAR OR DATES)<br><b>WWII</b>  |  | 16c. SOCIAL SECURITY NO<br><b>212 18 3189</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mildred M. Giorgilli - same address</b>                          |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypovolemic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Perforated Colon Ca</b>   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>4 hrs</b><br><b>3 wks</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>wound</b>   |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/30</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Small Bowel Obstruction</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22a. I certify that this hospital attended the deceased from <b>NOVEMBER 16, 1979</b> , to <b>NOVEMBER 30, 1979</b> , that (we) lost<br>saw the deceased alive on <b>11/30/79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>DOCTOR MURPHY MD</b>   |  | 22c. DEGREE<br><b>MD</b>   |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>             |  | 22e. DATE SIGNED<br><b>11/30</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Dec. 4, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>MD</b>           |  |   |  |   |  |
| 24. FUNERAL HOME<br><b>Schimunek Funeral Home, Inc.</b>   |  | 25. ADDRESS<br><b>3331 Brehms Lane</b>   |  | 26. DATE REGD BY REGISTRAR<br><b>DEC 4 1979</b>   |  | 27. REGISTRAR'S SIGNATURE<br><b>Anthony M. Brady</b>  |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN A GLENNON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>8</b> YEAR <b>79</b> |   |  | 2b. HOUR<br><b>8 42A</b> M   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>C</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>19</b> YEAR <b>09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SB6H</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Etching</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>B</b> 13c. CITY OR TOWN <b>Balt.</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2714 Hollins Ferry Rd</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>John T.</b> MIDDLE <b>G</b> LAST <b>Glennon</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LARRA</b> MIDDLE <b>ALEXANDER</b> LAST <b></b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>21301 6684</b>  |  | 17. INFORMANT<br>ADDRESS <b>Katherine Glennon</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br><b>410-</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>M.I.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hypertension Chronic Obstructive Lung Disease</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/8/79</b> , 19 <b>79</b> , to <b>11/8</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/8/79</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Brunno MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11/8/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Zileea Brunno</b>  |  |  |  | 22e. ADDRESS<br><b>SB6H 3001 S. Hanover St Balt.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>11/8/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Liatroy McBrady</b>   |  |

MEDICAL CERTIFICATION

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Western City

Electricity

Electricity



Western City

Western City

Western City

Western City

Western City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |         |  |                                 |  |  |
|--|---------|--|---------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE OF DEATH                                |                                 | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | 2a. DATE OF DEATH                                |                                 | 2b. HOUR   |  |
| FIRST MIDDLE LAST  |         | MONTH DAY YEAR                                   |                                 | HOUR MIN.  |  |
| William R Glover   |         | 11 12 79   |                                 | 9 40 A M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH                                 | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR                                       |  |
| M  | W       | MONTH DAY YEAR                                   | 67 YRS                          | MONTHS DAYS HOURS MIN.                                   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 9. BALTIMORE CITY OR COUNTY OF DEATH             |                                 | 10. USUAL OCCUPATION                                     |  |
| MD.  |         | BALTO. CITY                                      |                                 | (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |
| 11. CITY OR TOWN OF DEATH  |         | 12a. USUAL OCCUPATION                            |                                 | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |
| BALTO  |         | BALTO. CITY HOSP                                 |                                 | AUTO   |  |
| 13a. STATE   |         | 13b. COUNTY                                      |                                 | 13c. CITY OR TOWN  |  |
| MD.  |         | BALTO.   |                                 | ESSEX  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                         |                                 | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?              |  |
| FIRST MIDDLE LAST  |         | FIRST MIDDLE LAST                                |                                 | (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)         |  |
| JOHN GLOVER  |         | LOUISE SCHUCK                                    |                                 | UNK  |  |
| 17. INFORMANT  |         | 18. CAUSE OF DEATH                               |                                 | 19. SOCIAL SECURITY NO.                                  |  |
| ADDRESS  |         | PART I. DEATH WAS CAUSED BY:                     |                                 | 20. SOCIAL SECURITY NO.                                  |  |
| BERNICE GLOVER ABOVE   |         | IMMEDIATE CAUSE (a) Cardiorespiratory Arrest     |                                 | 21. SOCIAL SECURITY NO.                                  |  |
|  |         | DUE TO, OR AS A CONSEQUENCE OF                   |                                 | 22. SOCIAL SECURITY NO.                                  |  |
|  |         | (b) Upper Gastrointestinal Bleeding              |                                 | 23. SOCIAL SECURITY NO.                                  |  |
|  |         | DUE TO, OR AS A CONSEQUENCE OF                   |                                 | 24. SOCIAL SECURITY NO.                                  |  |
|  |         | (c)  |                                 | 25. SOCIAL SECURITY NO.                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |         |  |                                 |  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |                                 | 20a. AUTOPSY?  |  |
|  |         |  |                                 | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |         | 21b. TIME OF INJURY                              |                                 | 21c. HOW INJURY OCCURRED                                 |  |
|  |         | HOUR A.M. MONTH DAY YEAR                         |                                 | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY                             |                                 | 21f. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                 | STREET CITY OR TOWN COUNTY STATE                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost                           |         |  |                                 |  |  |
| saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated            |         |  |                                 |  |  |
| above, (I) (we) (did) (did not) view the body after death.   |         |  |                                 |  |  |
| 22b. SIGNATURE   |         | DEGREE   |                                 | 22c. DATE SIGNED   |  |
| D Siegel MD  |         |  |                                 | 11/22/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         | 22e. ADDRESS                                     |                                 | 22f. DATE REC'D. BY REGISTRAR                            |  |
| D Siegel   |         | Balt City Hosp                                   |                                 | NOV 16 1979  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY                       |  |
| BURIAL   |         | 11/14/79   |                                 | ST. STANISLAUS   |  |
| 23d. FUNERAL DIRECTOR  |         | 23e. LOCATION                                    |                                 | 23f. COUNTY  |  |
| J. E. CONNELLY   |         | BALTO.   |                                 | MD   |  |
| 23g. NAME  |         | 23h. ADDRESS                                     |                                 | 23i. REGISTRAR'S SIGNATURE                               |  |
| J. E. CONNELLY   |         | 300 MAJCE  |                                 | M. J. McBrady  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | REG. NO. 7 9 2 7 3 7 3                              |  |  |   |  |  |  |
|--|--|---|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MELVIN GEORGE GOERTZ</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 16 79</b> |  |  |   | 2b. HOUR<br><b>9:10P AM</b>                          |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 15 15</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 7b. HOURS MIN.                               |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                           |  |   |  |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |  |   |   | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret Security</b>          |  |   | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Municipal</b> |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>602 E. 30th Street</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>GEORGE GOERTZ</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARY A. MATTHEWS</b>   |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. IF YES, GIVE WAR OR DATES<br><b>WW 2</b>   |  | 16c. SOCIAL SECURITY NO.<br><b>220 09 8275</b>  |   | 17. INFORMANT ADDRESS<br><b>VAMC Clinical Records Baltimore, Md. 21218</b>                   |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest/respiratory arrest</b><br><b>2000</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diffuse Histiocytic Lymphoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 13, 1979</b> to <b>NOVEMBER 16, 1979</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 16, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Adhialif</b>  |  |   |  | DEGREE<br><b>M.D. PhD</b>   |   |  |  | 22b. DATE SIGNED<br><b>11/16/79</b>   |  |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Adhialif ALARIF</b>  |  |   |  | 22d. ADDRESS<br><b>3900 Loch Raven Blvd. Balto., Md. 21218</b>  |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/21/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>                   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm Flalkowski F.H. 2009 Eastern Avenue</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1979</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>Selma Bofreed   |  | MONTH DAY YEAR<br>Nov 10 79  |  |
| 3 SEX<br>FEMALE  |  | 2b. HOUR<br>8:02 AM  |  |
| 4 RACE<br>CAUCASIAN  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 26 1900   |  | 79   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hosp of Balto.  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| 13a. STATE<br>Md.  |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13c. COUNTY<br>Balto.  |  | 13d. STREET ADDRESS<br>#21215<br>3601 Clarks Lane, APT. 314  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY BUDLOW   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LEAH UNKNOWN  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNKNOWN NO   |  | 16b. SOCIAL SECURITY NO.<br>212-34-9865  |  |
| 17. INFORMANT<br>MR. HERBERT GOFREED   |  | ADDRESS<br>#21215<br>3601 CLARKS LA., APT. 314   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory failure<br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Metastatic carcinoma to liver<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) Primary carcinoma of Breast.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>0 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 month<br>1 month   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/1/79, 19, to 11/10/79, 19, that (I) (we) last saw the deceased alive on 11/8/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |
| 22b. SIGNATURE<br>Steven L. Joffe M.D.   |  | 22c. DATE SIGNED<br>11/9/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Steven L. Joffe M.D.  |  | 22e. ADDRESS<br>Sinai Hosp. of Balto.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>11-11-79  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW YOUNG MEN   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1979   |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED

NOV 1 1975



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

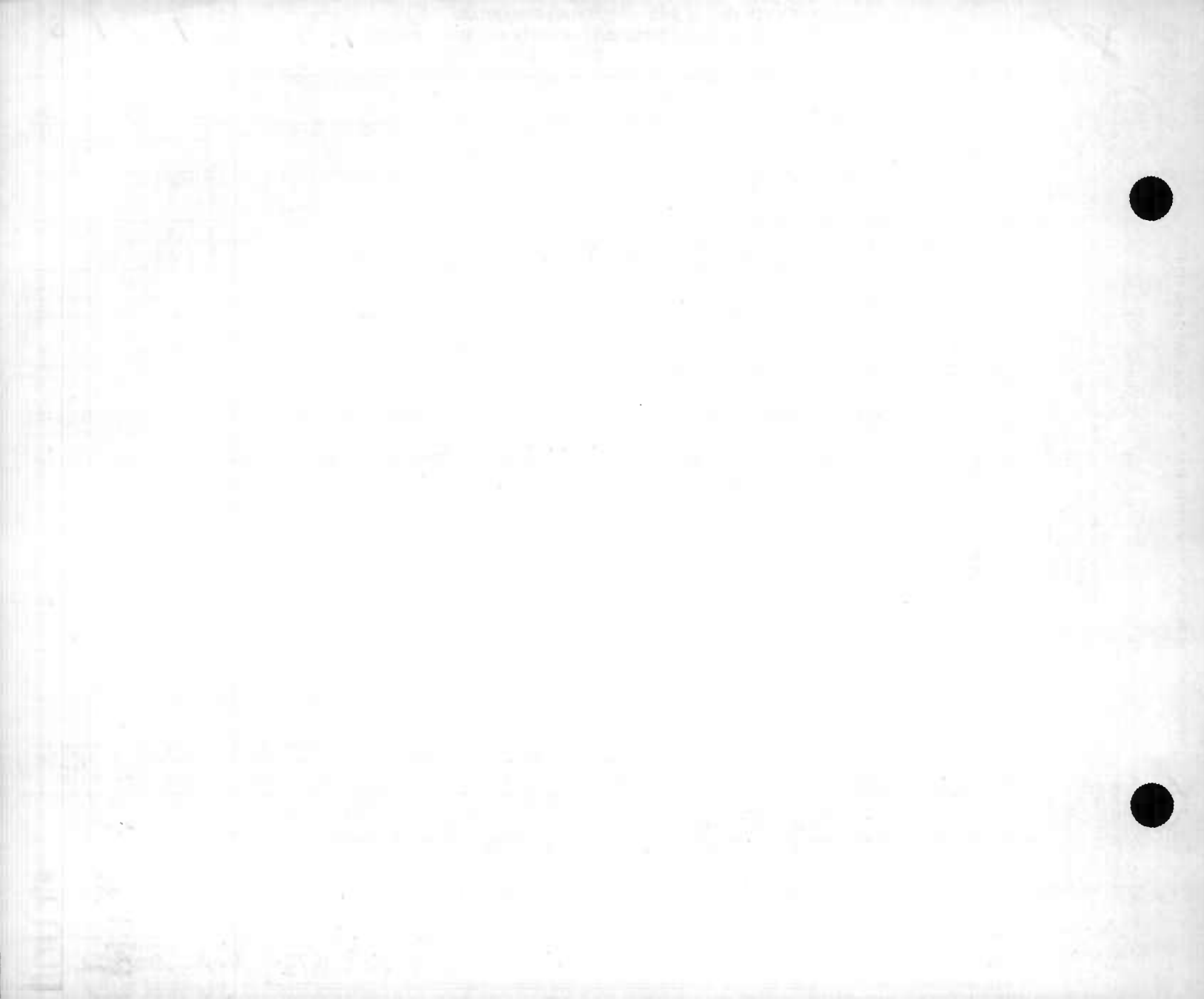
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 27 37 5

REG. NO.

|   |  |  |   |  |  |  |  |  |   |   |  |
|---|--|--|---|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CAROLYN MILLS GOLDER  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 26 79 |  |  | 2b. HOUR<br>605 AM   |  |  |   |   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3/7/1890   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 7b. IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self-Employed  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>-----   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3811 Canterbury Rd. 21218                                     |   |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Isaac O. Mills   |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Schenkel  |  |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>216.16.5528  |  | 17 INFORMANT<br>ADDRESS<br>Betty J. Ayres<br>10317 H Malcolm Circle Md. 21030<br>Pockeysville  |  |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Septic shock</u><br>486-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Pneumonia</u><br>(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>                            |  |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> 19 <u>79</u> to <u>11/26</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/26</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I did not) view the body after death. |  |  |   |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br><u>Alan Gaby</u>  |  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>11/26/79                    |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALAN GABY, M.D.  |  |  |   |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  |  |   | 23b. DATE<br>11/28/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                          |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley Inc. Balto., Md.   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 30 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Pietro McBrady</u>                                  |   |   |  |

BP \_\_\_\_\_

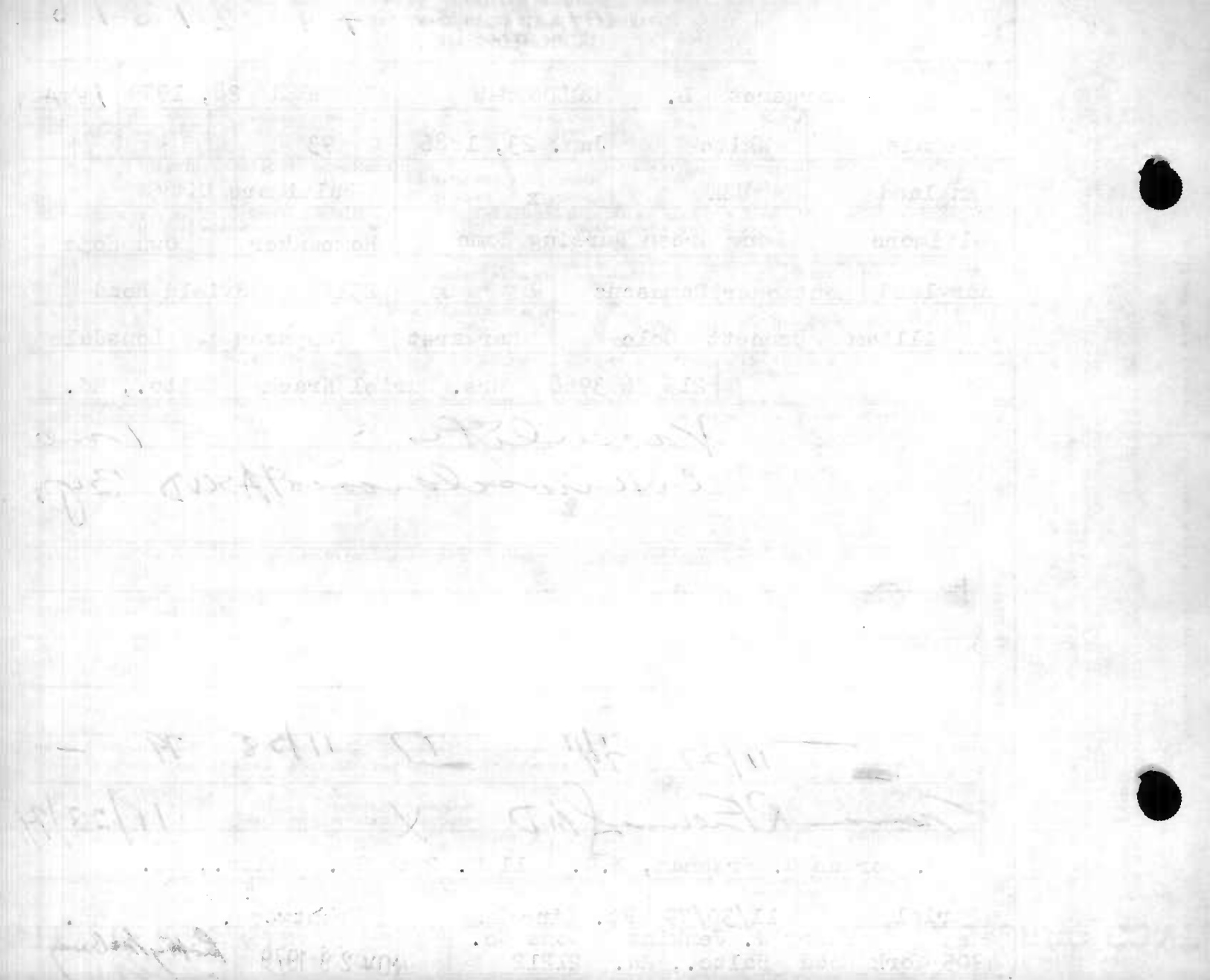


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 79 27376  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>Margaret L. GOLDSTRAW   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 28, 1979  |  | 2b. HOUR<br>1:45 AM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 23, 1886   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Damascus   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>25104 Woodfield Road  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Bennett Cole   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Joynson Lonsdale  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 36 3968   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Muriel Krach Balto., Md.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Vasculitis</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 mo</u><br><u>3 yr</u> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> 19 <u>77</u> to <u>11/28</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/27</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 27b. SIGNATURE<br><u>Norman R. Freeman, M.D.</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 27c. DATE SIGNED<br><u>11/28/79</u>  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Norman R. Freeman, M.D.   |  |  |  | 27e. ADDRESS<br>11 W. 29th St. Balto., Md.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/30/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood Md.                                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 29 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McBrady</u>  |  |  |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

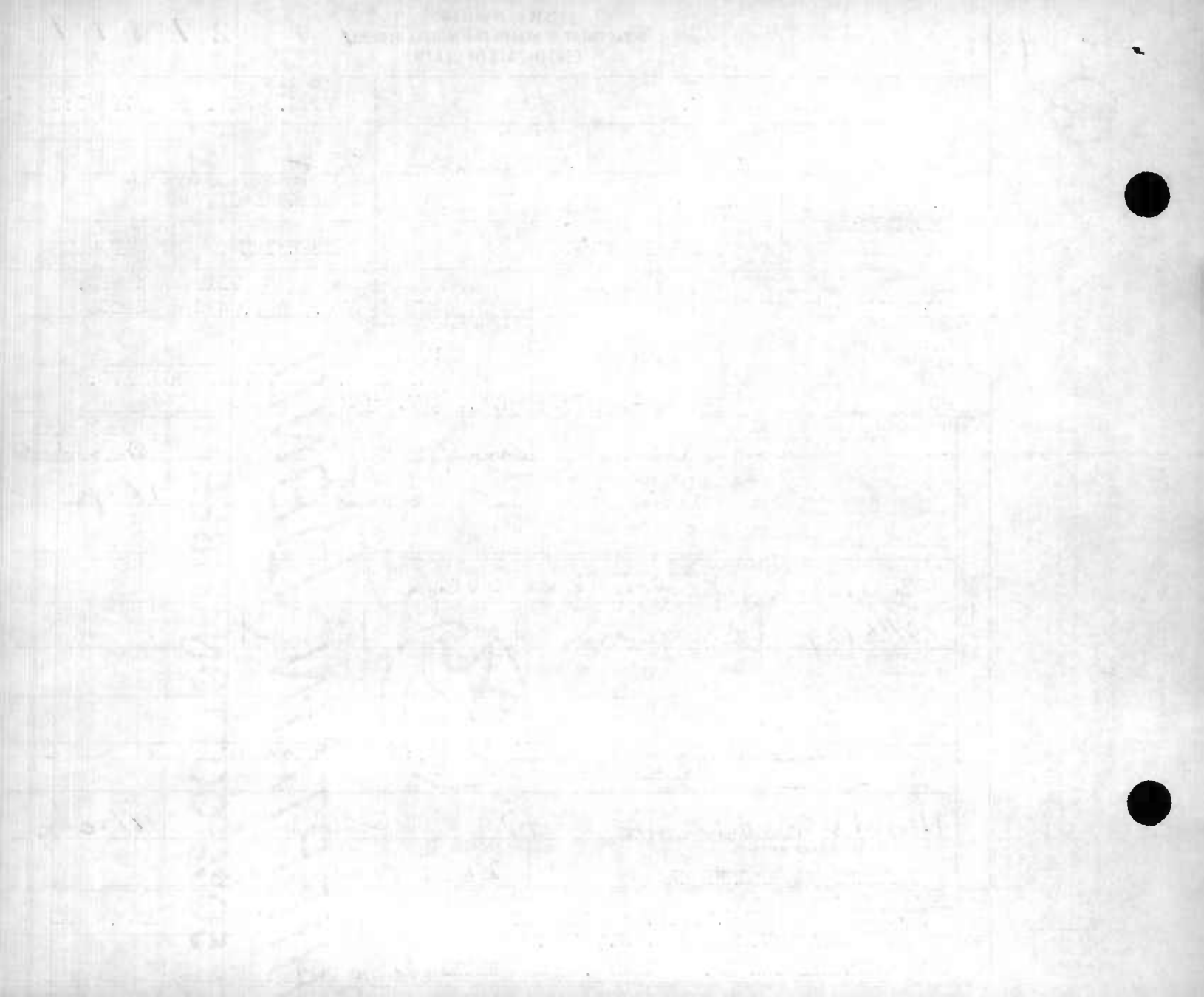
|  |  |   |   |  |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MYRA M. GOOD  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>TUES., NOV. 20, 1979 |  |  | 2b. HOUR<br>A. M.<br>7:26  |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 15, 1904  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 74 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |
| 10. CITY OF DEATH<br>MARYLAND  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN STATE, GIVE STATE AND CITY)<br>SINAL HOSPITAL |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR WORKING LIFE)<br>HOUSEWIFE                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. CITY BALTIMORE 13c. COUNTY BALTIMORE  |  |   |   |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>NATHAN METZENBAUM  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BETTYE STERN  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-46-1745  |   | 17. INFORMANT<br>ADDRESS<br>LOUIS L. GOOD 7219 PARK HTS.<br>AVE., APT. 402 #21208  |  |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerosis of coronary arteries</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>10 yr</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u> |  |   |   |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Carcinoma of colon - metastatic</u>   |  |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>10/16/79   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma of colon  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>04/27</u> , 19 <u>75</u> , to <u>Nov. 20</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>04/27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Herbert Gundersheimer</u>   |  |   |   | DEGREE<br>1707<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>10/20/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HERBERT GUNDERSHEIMER   |  |   |   | 22e. ADDRESS<br>2601 14th Ave  |  |  |  |  |  |
| 23a. BURIAL OR CREMATION<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>NOV. 21, 1979  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>DRUID RIDGE  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PIKESVILLE BALTO. MD                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD.  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Frederick Helms</u>                                 |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |   |   |  |  |  |
|--|--|---|---|--|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>BABY GIRL GOODE (WENDY)</b>   |  |   |   |  | 20. DATE OF DEATH<br>Month <b>11</b> Day <b>23</b> Year <b>79</b>                       |   |  | 2b. HOUR<br><b>6:45 AM</b>                                       |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH<br><b>11. 23. 79.</b>   |   | 6. AGE (In years last birthday)<br>YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>UMH.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE CITY.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>UNIV. OF MD. HOSP.</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>725 Lenox Street</b>                |  |
| 14. FATHER'S NAME<br>First <b>EDWARD. S.</b> Middle <b>WATKINS</b> Last <b>GOODE</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>WENDY.</b> Middle <b>GOODE</b> Last <b>GOODE</b> |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>WENDY GOODE. 725 LENNOX ST. BALTO. MD. 21217</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>7400</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ANENCEPHALY.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11. 23. 79</b> , 19 <b>79</b> , to <b>11. 23.</b> , 19 <b>79</b> , that (I) (we) lost the deceased alive on <b>11. 23. 79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>M. J. Desai</b>   |  | DEGREE<br><b>DR. M. J. DESAI</b>  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                  |   | 22c. DATE SIGNED<br><b>11. 23. 79</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS<br><b>UNIV. OF MD. HOSP. GREENE ST. BALTO. MD.</b>   |   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 23b. DATE<br><b>12/6/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Anatomy Board</b>   |  | ADDRESS<br><b>Balto., Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 7 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

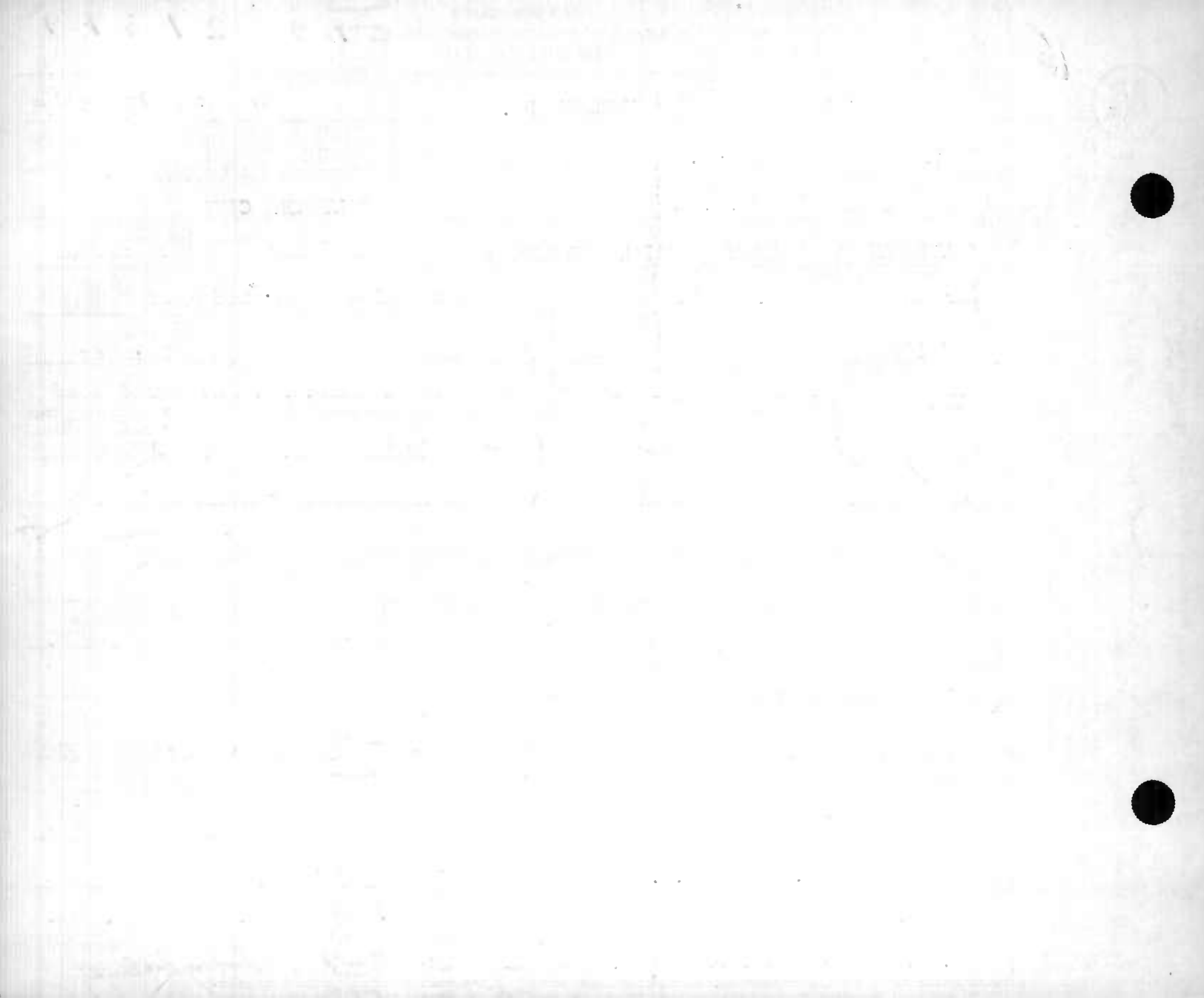
BP

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 3 7 9

|   |  |  |  |
|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HOWARD GOODMAN   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 27 79  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Cauc.   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 12 1909   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Physician   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medicine  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland   |  | 13b. COUNTY<br>Balto.  |  |
| 13c. CITY OR TOWN<br>Timonium   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Isadore Goodman   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rae Dember  |  |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>220-44-2282  |  |
| 17. INFORMANT<br>ADDRESS<br>Elizabeth Lanahan, 304 Gateswood Road   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u><br>431-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs.                              |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 19 <u>79</u> , to <u>11/27</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>Warren M. Ross M.D.</u>  |  | 22c. DATE SIGNED<br><u>11/27/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WARREN M. ROSS M.D.  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/30/79  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Balto. Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. E. Lowell Lemmon   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 29 1979   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Anthony A. Brady</u>   |  |  |  |

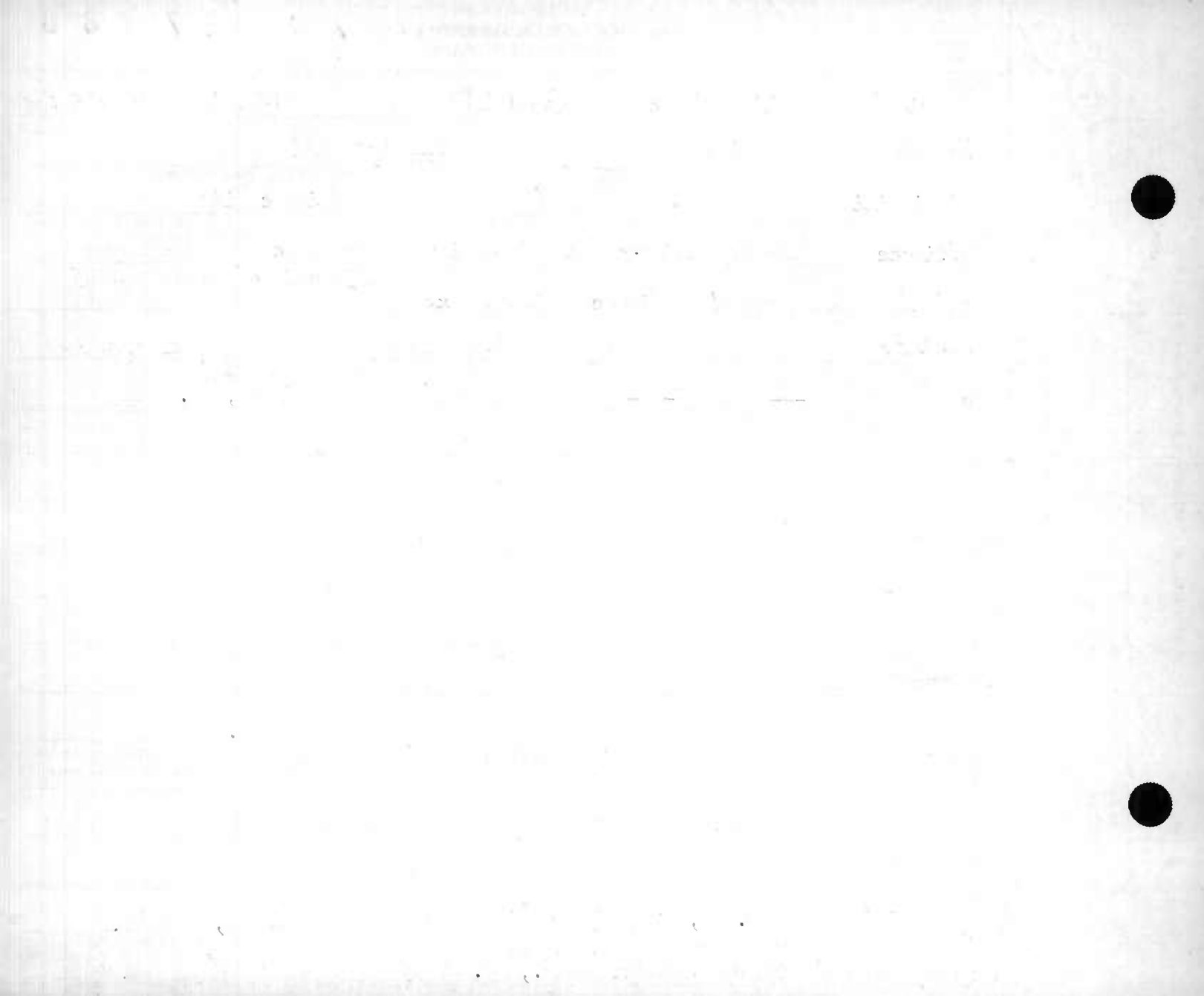


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |  |   | 7 9 2 7 3 8 0  |  |  |  |
|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |   |  |   | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Avis <del>XXXXXXXX</del> Elenar GOULD   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 9 1979   |  | 2b. HOUR<br>6:59 P.M.  |  |  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 12 1922                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.             |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                          |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |   | 13b. COUNTY<br>Anne Arundel  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br>225 Southernly Road 21225<br>225 SOUTHERLY ROAD |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GOFF   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NELLIE LINGER         |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>235-40-1842 |   | 17. INFORMANT<br>225 Southernly Road<br>Baltimore, Md. 21225   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>PERFORATED ABD. VISCUS</u><br>1809<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEPTIC SHOCK</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>OSTEOGENIC SARCOMA</u><br>5 day 2 |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Cervical CA - Autolysis Necrosis</u>   |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/06/79</u> 19 <u>79</u> , to <u>11/09</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/09</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>M. Mostaan M.D.</u>   |   | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11/09/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>M. MOSTAAN</u>   |   | 22e. ADDRESS<br><u>50 B.G. 1st</u>                                     |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |   | 23b. DATE<br><u>Nov. 13, 1979</u>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Maryland</u>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>McCully Funeral Home of Brooklyn Balto., Md.</u>  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 14 1979</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |                            |  |   |
|---|--|--|--|--|---|--|----------------------------|--|---|
| 1 - FOR STATE REGISTRAR   |  |  |  |  |   |  |                            |  |   |
| REG. NO.  |  |  |  |  |   |  |                            |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH P GREAVER</b>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>18</b> YEAR <b>79</b>               |  | 2b. HOUR<br><b>7:05</b> AM |  |   |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>29</b> YEAR <b>91</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |                            | IF UNDER 1 YEAR<br>MONTHS <b>8</b> DAYS <b>18</b>  |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |                            |  |   |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |                            | 12b KIND OF BUSINESS OR INDUSTRY   |   |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Baltimore</b>   |  | 13c CITY OR TOWN<br><b>Arbutus</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                            | 13e STREET ADDRESS<br><b>4746 Aldgate Green 21227</b>  |   |
| 14 FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>-</b> LAST <b>Akers</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>-</b> LAST <b>Roupe</b> |  |                            |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br><b>213-74-6694</b>  |  | 17 INFORMANT<br>ADDRESS <b>Balto., Md. 21227</b><br><b>Gladys Thomas-4746 Aldgate Green-</b>   |   |  |                            |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BACTERIAL PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>   |  |  |  |  |   |  |                            |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 weeks</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |                            |  |   |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |                            |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                            |  |   |
| 22a I certify that (I) (this hospital) attended the deceased from <b>11/7</b> , 19 <b>77</b> , to <b>11/18</b> , 19 <b>77</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/18</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |                            |  |   |
| 22b. SIGNATURE<br><b>C. A. Arcangues</b>  |  |  |  | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                            | 22c. DATE SIGNED<br><b>11/18/79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. A. ARCANGUES</b>   |  |  |  | 22e ADDRESS<br><b>900 CATON AVE. BALTIMORE, MD. 21229</b>  |   |  |                            |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-21-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Clarksburg, Harrison W. Va.</b>   |                            |  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS<br><b>4107 Wilkens Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                            |  |   |

BALTIMORE CITY

BALTIMORE ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ADMISSION

DATE

TIME

PLACE

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

X

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be filed with the State Department of Health and Mental Hygiene within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove the top portion of this certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18c G541 3/3/80 dad  
 1 - STATE REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 7 9 2 7 3 8 2  
 REG. NO.

|  |  |   |  |  |   |  |  |   |  |
|--|--|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Arthur Green  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 26, 1979 |  |   | 2b. HOUR<br>3:04 PM  |  |   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 22 1908  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland   |  |   | 13c. CITY OR TOWN<br>Baltimore                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>201 N. Broadway Apt 13D |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Christopher Green  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hester  |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-12-0246  |  | 17. INFORMANT<br>ADDRESS<br>MARION GREEN 618 SHIPVIEW WAY  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Right lower lobe pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>poor pulmonary toilet</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><u>Cervinoma of neck</u><br><u>at home - he arrested just several hrs.</u><br>adequate suction or postural drainage while |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Co-HEN</u>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET  |   | CITY OR TOWN   |  | COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>on 11/26</u> 19 <u>79</u> , to _____, 19 _____, that (I) (we) last saw the deceased alive on <u>11/26</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, please explain and view the body after death.)<br><u>Natural</u>  |  |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><u>B. B. B. B.</u>   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |   | 22c. DATE SIGNED<br>11/26/79   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B. B. B. B. MD  |  | 22e. ADDRESS<br>JHH   |  |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>12/1/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Calvary   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MARYLAND  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William C. Brown F.H.  |  |   |  | ADDRESS<br>1206-08 W. North Ave  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony M. Brady</u> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 7 9 2 7 3 8 3<br>REG. NO.   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>ESTELLA P. GREEN</b>   |  |  |  | 2b. HOUR<br><b>9:50 AM</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>negro</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 15 1891</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>88</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city MD</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore city</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b>                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>md</b>   |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Mc Kinley</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Maggie Mc Kinley</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>—</b>  |  |
| 17. INFORMANT<br><b>Leonard Levin</b>   |  |  |  | ADDRESS<br><b>Baltimore 2400 Pennsylvania Ave</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrhythmia associated with</b><br><b>1952</b> DUE TO, OR AS A CONSEQUENCE OF <b>without sufficient heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>cerebral insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>probable abdominal malignant</b> |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> , 19 <b>79</b> , to <b>11/22</b> , 19 <b>79</b> , that (I) (we) lost the deceased alive on <b>11/22</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Joseph J. Kim</b>  |  | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/22/79</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH J. KIM</b>   |  | 22e. ADDRESS<br><b>Provident Hospital</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/29/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Calvary</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brooklyn AA md</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Furnell B. Oden</b>  |  | ADDRESS<br><b>Balto. md</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 5 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Selinsky</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 2 7 3 8 4  |  | REG. NO.   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Pauline D. Green  |  |  |  | 2r. DATE OF DEATH<br>MONTH DAY YEAR<br>11 19 79  |  | 2b. HOUR<br>6 a.m.   |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Black  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>2 14 1893   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1725 Clifview Ave |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13c. STREET ADDRESS<br>1006 Creek Street   |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Levi Davis  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Isabelle Pringle  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17 INFORMANT ADDRESS<br>Helen Skipper 390 Bond St. Bridgeport Conn. 06610  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma @ lung &amp; metastases</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 1/2 yrs.</u> |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> 19 <u>78</u> to <u>6/19</u> 19 <u>79</u> , that (II) (we) last saw the deceased alive on above (II) (we) did (did not) view the body after death 9/17 19 79, and that in (m) (our) opinion death occurred on the date and hour and from the causes stated  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>J. P. Pargament M.D.</u>  |  |  |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/21/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. PARGAMENT  |  |  |  | 22e. ADDRESS<br>124 Wall St. Balt., Md 21230   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11-24-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>Isaiah L. Brown & Son PA 1913 W. Balto. St.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text block containing several lines of typed information, possibly a memorandum or report summary.]

[Large block of illegible text, likely the main body of a letter or report, consisting of multiple paragraphs.]

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 7 9 2 7 3 8 5  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Rida P. Green</i>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>11 26 1979</i>   |  | 2b. HOUR <i>5:15 A.M.</i>   |  |
| 3. SEX <i>Female</i>   |  | 4. RACE <i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <i>6 18 1883</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>96</i> YRS. <input type="checkbox"/> UNDER 1 YEAR MONTHS <input type="checkbox"/> UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD.</i>  |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Edge wood Nursing Home</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <i>Md</i>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Edward Peake</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>  |  | 13e. STREET ADDRESS <i>5101 Whiteford Ave</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>  |  | 16b. SOCIAL SECURITY NO. <i>2120134680</i>   |  | 17. INFORMANT ADDRESS <i>Peggy Lucas 1315 Plymouth Rd</i>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic C-V Disease</i><br>4292<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20yr.</i> |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 19 1979</i> , to <i>Nov 26 1979</i> , that (I) (we) last saw the deceased alive on <i>Nov 19 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <i>Frederick J. Vollmer M.D.</i> DEGREE <i>M.D.</i>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <i>11-26-79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>FREDERICK J. VOLLMER</i>  |  |  |  | 22e. ADDRESS <i>6100 YORK RD BALTO 21212</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |  | 23b. DATE <i>11/17/79</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Ch. Cemt</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto Md</i>   |  |
| 24. FUNERAL DIRECTOR NAME <i>Mitchell-Wiedotold Home</i> ADDRESS <i>6500 York Rd</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>NOV 29 1979</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Anthony McBrady</i>   |  |

BP

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(VR A15 ME (5))  
30M 7/73

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR RECORDS.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                  |   |  |   |  |   |  |   |  |                                     |  |
|---|------------------|---|--|---|--|---|--|---|--|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |                  | FIRST<br>Grace  |  | MIDDLE<br>Greene  |  | LAST<br>Greene  |  | 6a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> 11 9 1979<br>MONTH DAY YEAR |  | 2b. HOUR<br>M<br>1:30 P             |  |
| 3. SEX<br>Female  | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 28 1961   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>61 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD<br>11 16 1979<br>MONTH DAY YEAR  |  | 2d. HOUR<br>M                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GA.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                      |  |   |  |                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1922 Harryweiss Court |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                        |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                     |  |
| 13a. STATE<br>MD  |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1922 Harryweiss Court  |  |                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>unk  |  | 16b. SOCIAL SECURITY NO.<br>229097671   |  | 17. INFORMANT<br>Mrs. Jean Wright   |  | ADDRESS<br>16325 130th Ave<br>LA NY |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |                  |   |  |   |  |   |  |   |  |                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                  |   |  |   |  |   |  |   |  |                                     |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |                                     |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Medical causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |  |   |  |   |  |                                     |  |
| ACTUAL SIGNATURE<br><u>Thomas D. Smith</u>  |                  | TITLE (SPECIFY)<br>Deputy Chief   |  |   |  |   |  | MEDICAL EXAMINER  |  | DATE SIGNED<br>11/17/79             |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |                  | ADDRESS<br>111 Penn St.   |  |   |  |   |  | Balto., MD.   |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |                  | 23b. DATE<br>11/23/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Md.                                   |  |   |  |                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C Brown Comm.  |                  | ADDRESS<br>1206-08 W, North Ave   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 27 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McCreedy</u>  |  |   |  |                                     |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR<br>1. STATE<br>REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 7 9 2 7 3 8 7<br>REG. NO.   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Rosetta Maude Greene</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 17 79</b>  |  |  |  | 2b. HOUR<br><b>6:10 P.M.</b>  |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB 5, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                    |  | 7. IF UNDER YEAR<br>MONTHS DAYS<br><b>11 17</b>   |  | 8. IF UNDER 4 HRS<br>HOURS MIN<br><b>6 10</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>IRELAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Dexter Medical Ctr.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   |  | 13b. CITY OR TOWN<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2232 GRUBB ROAD</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES O'CONNOR</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE MAUDE WHITE</b>  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>579-50-9748</b>   |  | 17. INFORMANT<br><b>DAUGHTER</b>  |  |  |  | ADDRESS<br><b>1615 COLONIAL WAY<br/>FREDERICK, MARYLAND</b>                                     |  |   |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atherosclerosis - Chronic</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Brain Syndrome</b><br>(b) <b>Brain Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Seizure Disease</b><br>(c) <b>Seizure Disease</b>            |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-29-79</b> 19 <b>79</b> to <b>11-17-79</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11-17-79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Dr. Sawicki</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>4/17/79</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Sawicki</b>  |  |   |  | 22e. ADDRESS<br><b>611 S. Charles St. and 21230</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   |  | 23b. DATE<br><b>11/21/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET CEMETERY</b>                     |  | 23d. LOCATION<br>WASHINGTON, D.C. STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b><br>ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John A. Kelly</b>  |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 3 8 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Jessie Greenlay</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 79</b>                                    |  | 2b. HOUR<br><b>6:10 PM</b>                                  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 10 1890</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mass.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Federal Hill Nursing Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Not Documented</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None Documented</b> |
| 13a. STATE<br><b>Unknown</b>   |   | 13b. COUNTY<br><b>Unknown</b>   | 13c. CITY OR TOWN<br><b>Unknown</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Greenlay</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unice</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216-28-6106A</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Ruth Greenlay 229 Lincoln Street, Balto.</b>          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dementia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>S/P D Hyp Ex</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (1) <u>this hospital</u> attended the deceased from _____, 19_____, to _____, 19_____, that (1) <u>we</u> lost saw the deceased alive on _____, 19_____, and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (2) <u>we</u> (did) <u>not</u> view the body after death.                               |   |   |   |  |   |
| 22b. SIGNATURE<br><b>E J. Folkemer, MD</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>11/15/79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Folkemer</b>   |   | 22e. ADDRESS<br><b>FED. Hill Nursing Home</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>11-16-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Calvary</b>                              |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b>   |   | 23e. DATE REC'D BY REGISTRAR<br><b>NOV 16 1979</b>  |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William J. Folkemer 3207 W. ...</b>   |   |   |   |  |   |

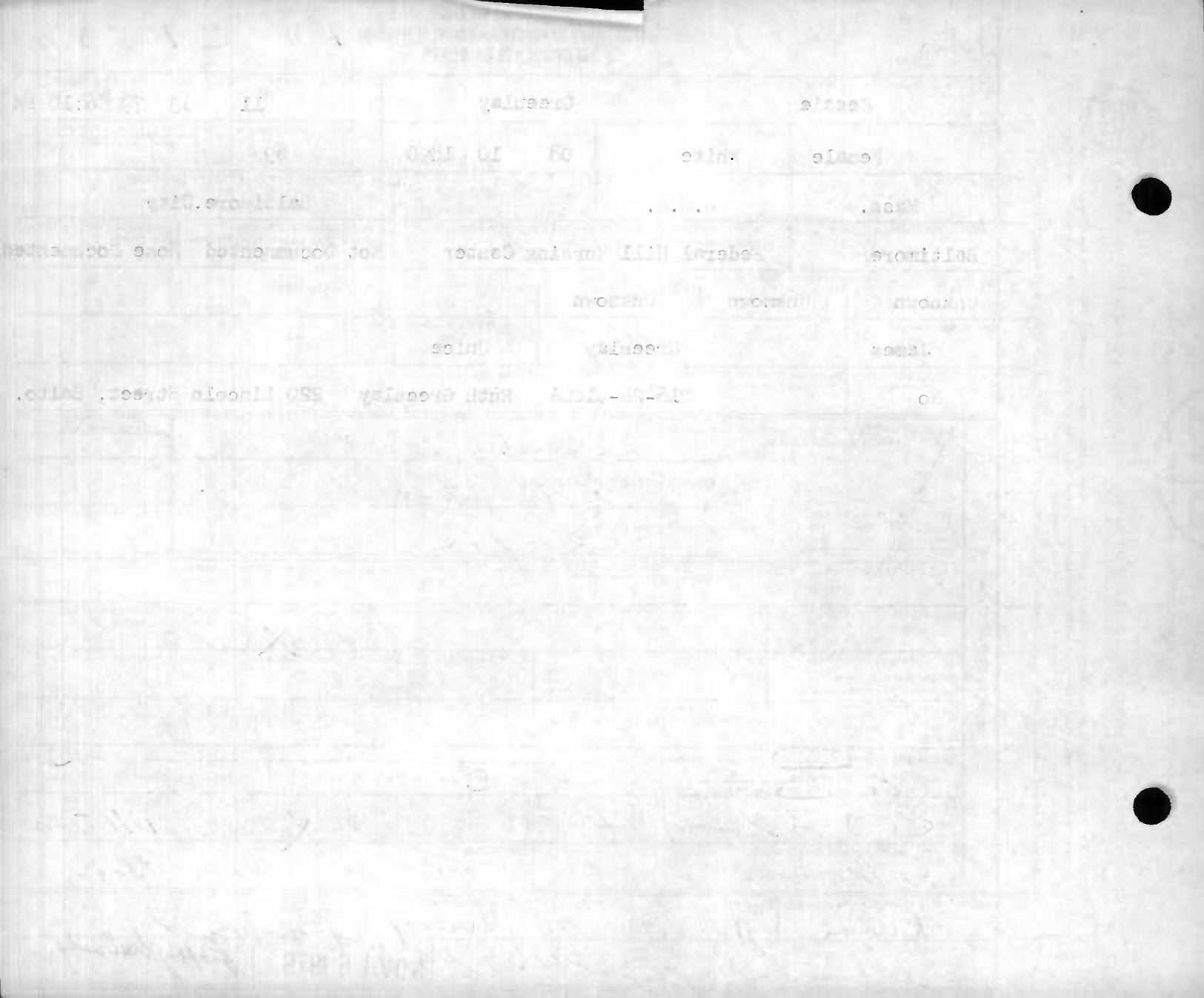
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

**1- FOR  
STATE  
REGISTRAR**

|   |         |  |  |  |  |  |  |  |  |  |  |                     |  |     |  |   |  |   |  |
|---|---------|--|--|--|--|--|--|--|--|--|--|---------------------|--|-----|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE KNOWN<br>OF DEATH   |  | ESTI-<br>MATED                             |  | MONTH               |  | DAY |  | YEAR  |  | 2b. HOUR  |  |
| George  |         | A.   |  |  |  | Grier  |  | 11   |  | 4  |  | 19                  |  | 79  |  |   |  | M   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.   |  | 7c. DATE<br>PRONOUNCED<br>DEAD             |  | MONTH               |  | DAY |  | YEAR  |  | 2d. HOUR  |  |
| Male  | Black   | 8 28 53  |  | 26 YRS.  |  |  |  |  |  | 11   |  | 5                   |  | 19  |  | 79  |  | 8:00<br>P M                                     |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |                     |  |     |  |   |  |   |  |
| SOUTH CAROLINA  |         | US   |  |  |  |  |  | Baltimore City, MD.  |  |  |  |                     |  |     |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY       |  |                     |  |     |  |   |  |   |  |
| Baltimore   |         | 1924 W. Mosher Street  |  |  |  | DISABLED   |  |  |  |  |  |                     |  |     |  |   |  |   |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |  |  |                     |  |     |  |   |  |   |  |
| MARYLAND  |         |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 1924 W. MOSHER STREET  |  |  |  |                     |  |     |  |   |  |   |  |
| 14. FATHER'S NAME   |         |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |                     |  |     |  |   |  |   |  |
| FIRST MIDDLE LAST   |         |  |  | FIRST MIDDLE LAST  |  |  |  |  |  |  |  |                     |  |     |  |   |  |   |  |
| RAYMOND   |         |  |  | GRIER  |  |  |  | BEATRICE   |  |  |  | PEARSON             |  |     |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT  |  |  |  | ADDRESS             |  |     |  |   |  |   |  |
| YES   |         |  |  | 215-60-2740  |  |  |  | BEATRICE JOHNSON   |  |  |  | 4021 WOODHAVEN AVE. |  |     |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>9530<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <u>Hanging</u><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |  |  |  |  |  |  |                     |  |     |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d).   |         |  |  |  |  |  |  |  |  |  |  |                     |  |     |  |   |  |   |  |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |  |  |  |  |  |  |                     |  |     |  | 20. AUTOPSY?  |  |   |  |
|   |         |  |  |  |  |  |  |  |  |  |  |                     |  |     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 11 4 19 79   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject hanged self |  |  |  |                     |  |     |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK  |         |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>home |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1924 W. Mosher St., Baltimore Md.               |  |  |  |                     |  |     |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |  |  |  |  |  |  |  |  |                     |  |     |  |   |  |   |  |
| ACTUAL<br>SIGNATURE   |         |  |  | TITLE (SPECIFY)<br>Assistant   |  |  |  | DATE<br>SIGNED   |  |  |  | 11/6/79             |  |     |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         |  |  | ADDRESS  |  |  |  |  |  |  |  |                     |  |     |  |   |  |   |  |
| Virginia L. Dolan, M.D.   |         |  |  | 111 Penn Street  |  |  |  |  |  |  |  |                     |  |     |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |                     |  |     |  |   |  |   |  |
| BURIAL  |         |  |  | 11-10-79   |  | MT. AUBURN   |  |  |  | BALTIMORE MARYLAND                         |  |                     |  |     |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |         |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                     |  |     |  |   |  |   |  |
| PHILLIPS FUNERAL HOME 21-27 N. MONROE ST.   |         |  |  | NOV 9 1979   |  |  |  | <i>Patricia A. Brady</i>   |  |  |  |                     |  |     |  |   |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME 5)  
30M 7/73

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

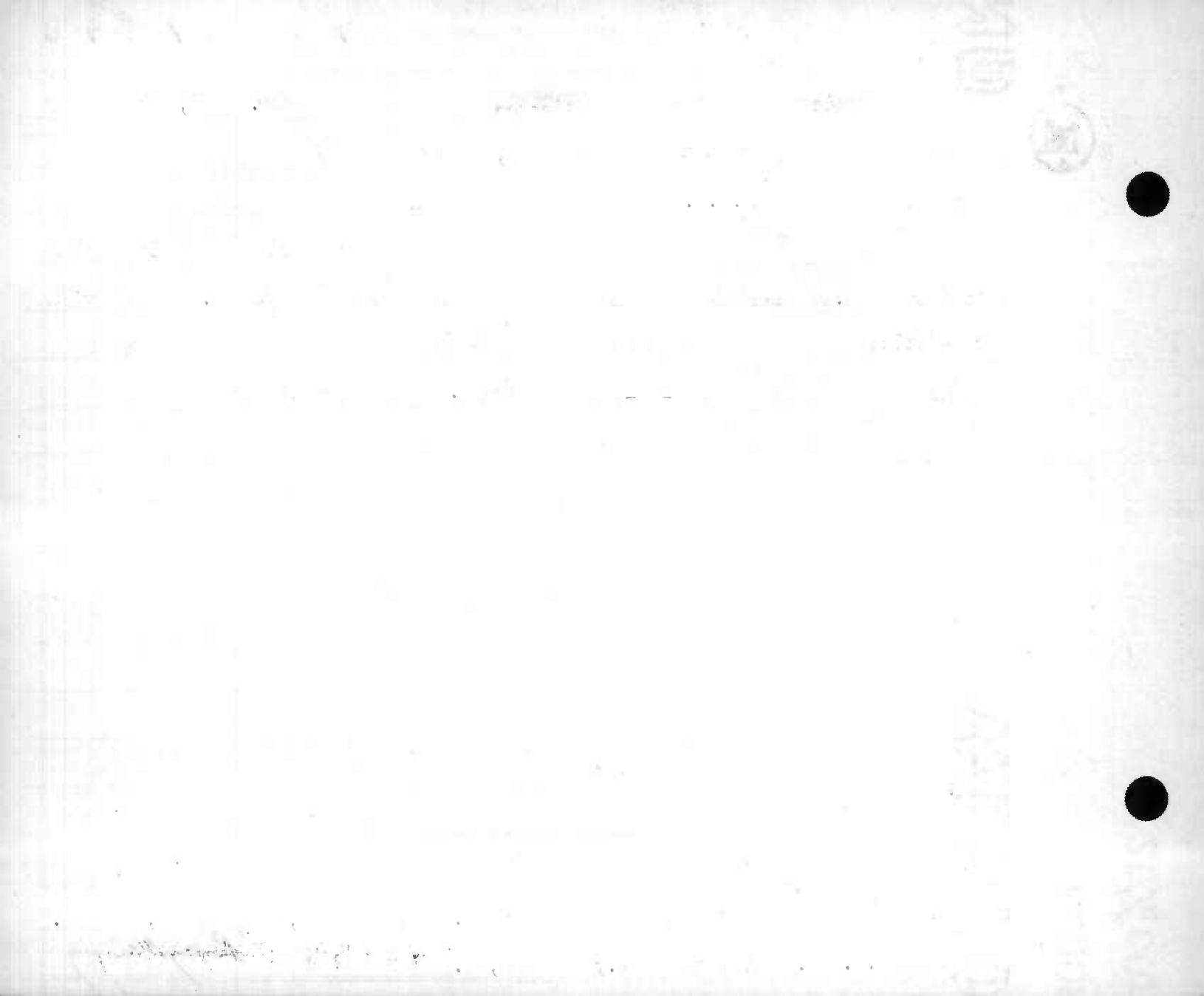


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 7 9 2 7 3 9 0  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><i>Marie</i>   |  | MIDDLE<br><i>Elizabeth</i>  |  | LAST<br><i>Grierson</i>   |  | 2a. DATE OF DEATH<br>MONTH<br><i>Nov.</i> DAY<br><i>17,</i> YEAR<br><i>79</i>  |  | 2b. HOUR<br><i>5:04 AM</i>   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Caucasian</i>   |  | 5. DATE OF BIRTH<br>MONTH<br><i>May</i> DAY<br><i>12,</i> YEAR<br><i>1912</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>67</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br><i></i> DAYS<br><i></i>   |  | IF UNDER 24 HRS<br>HOURS<br><i></i> MIN.<br><i></i>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.                         |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SOUTH BALT. GEN. HOSPITAL</i> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Beautician</i>                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Hair Stylist</i>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Anne Arundel</i>  |  | 13c. CITY OR TOWN<br><i>Pasadena</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><i>239 Mallard Rd.</i> 21122  |  |
| 14. FATHER'S NAME<br>FIRST<br><i>Frederick</i> MIDDLE<br><i></i> LAST<br><i>Grierson</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>Estelle</i> MIDDLE<br><i></i> LAST<br><i>Unknown</i>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WW 2</i> <i>220-14-9290</i> |  | 17. INFORMANT<br>ADDRESS<br><i>Helen V. Cook Same as #13</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>HEPATO RENAL SYNDROME</i><br><i>5722</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>HEPATIC ENCEPHALOPATHY</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i></i> P.M. <i></i> <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br><i></i>  |  | CITY OR TOWN<br><i></i>   |  | COUNTY<br><i></i>  |  | STATE<br><i></i>   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/18</i> , 19 <i>79</i> , to <i>11/12</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>11/12</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>N. Blumh</i>  |  |   |  |   |  | DEGREE<br><i></i>   |  | 22c. DATE SIGNED<br><i>11/12/79</i>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>N. Blumh</i>   |  |   |  |   |  | 22e. ADDRESS<br><i>SOUTH BALT GEN. HOSPITAL</i>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11/20/1979</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Mem. Park</i>  |  | 23d. LOCATION<br>CITY OR TOWN<br><i>Dorsey,</i>   |  | COUNTY<br><i>Howard,</i>   |  | STATE<br><i>Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Mc Cully F.H. Mtn. &amp; Tick Neck Rds.; Pasadena, Md.</i>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 19 1979</i>                                       |  | 25b. REGISTRAR'S SIGNATURE<br><i>History Helms</i>   |  |  |  |





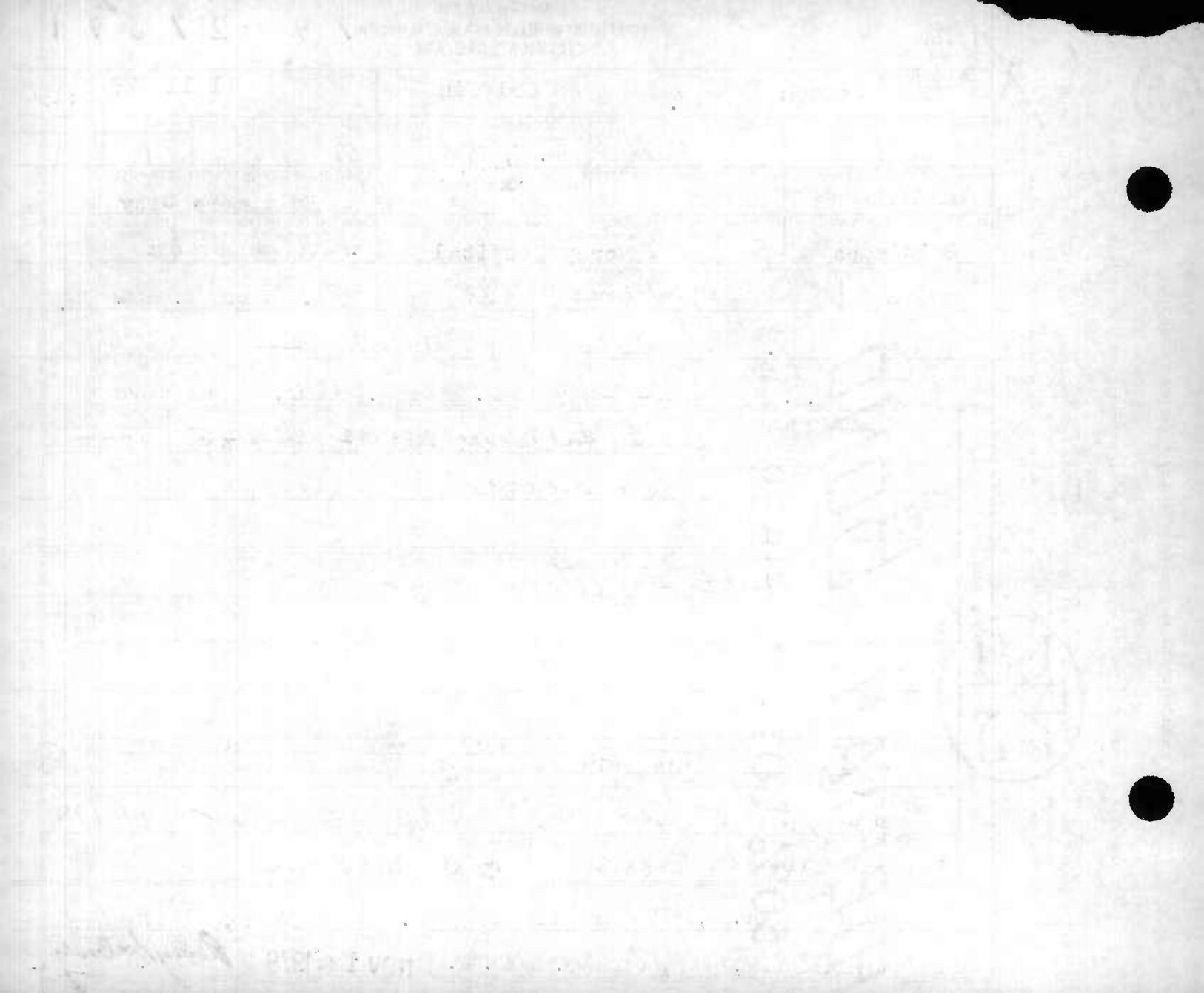


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE REGISTRAR  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 7 9 2 7 3 9 1   |                                   |  |  |  |
|--|--|--|--|---|--|---|--|---|-----------------------------------|--|--|--|
| 1 - STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |                                   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Joseph V. Griffin  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 11 79  |  |   |  | 2b. HOUR<br>8:15a <sub>M</sub>  |                                   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 31, 1915  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |                                   | IF UNDER 24 HRS. HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |   |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Fire Communication |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET ADDRESS<br>9 W. Clement St. Balto Md.  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph P. Griffin   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth Stindt  |  |   |  |   |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>W.B. 2 212-07-5149  |  | 17. INFORMANT ADDRESS<br>Mrs. Regina B. Griffin, Same as above                      |  |   |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease - MS + MI - class 4E</u><br>396 - DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe COPD</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 yrs |  |  |  |   |  |   |  |   |                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Multiple Colonic polyps</u>  |  |  |  |   |  |   |  |   |                                   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |   |                                   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                      |  |   |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/30</u> , 19 <u>79</u> , to <u>11/11</u> , 19 <u>79</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>11/11</u> , 19 <u>79</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did not view the body after death.  |  |  |  |   |  |   |  |   |                                   |  |  |  |
| 22b. SIGNATURE<br><u>Fredric Stewart Sirkis MD</u>   |  |  |  | DEGREE<br>MD  |  |   |  | 22c. DATE SIGNED<br>11/11/79  |                                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FREDRIC STEWART Sirkis  |  |  |  | 22e. ADDRESS<br>MERCY HOSPITAL  |  |   |  |   |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>Nov. 15, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemt.                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                   |                                   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ruby Helms</u>                                     |  |   |                                   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   |  |   |   |   |   | 7 9 2 7 3 9 2                                    |  |  |
|--|--|--|---|---|--|---|---|---|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |   |   | REG. NO.   |   |   |   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lillian Griffin</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 7 79</b>                             |   |   | 2b. HOUR<br><b>M</b>  |   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>B</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 8 97</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS                  |   | IF UNDER 1 YEAR MONTHS DAYS   |   | IF UNDER 24 HRS. HOURS MIN.                      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>912 E. Eager St</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)     |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  |   |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>912 E. Eager St.</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jeremiah Henry</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sophia Vaughn</b>             |   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><b>Herman Griffin, Jr. 2007 E. Oliver St.</b>  |  |   |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>COLON CANCER</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |   |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>malnutrition - cachexia</b>  |  |  |   |   |  |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7</b> , 19 <b>78</b> , to <b>11</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>8</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.           |  |  |   |   |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Allen A. Civello</b>  |  |  |   |   | DEGREE<br><b>MD</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/9/79</b>               |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allen A. Civello</b>   |  |  |   |   | 22c. ADDRESS<br><b>GOIN. BROADWAY Balto Md.</b>                                |   |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11/12/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                  |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co., Md.</b>   |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm C March F/H</b>   |  |  |   |   | ADDRESS<br><b>1101 E. North Avenue</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THOMAS L GRIFFIN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>21</b> YEAR <b>79</b> |   |  | 2b. HOUR<br><b>4:20 A.M.</b>  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>  |   | 5 DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>22</b> YEAR <b>07</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, Baltimore, Maryland 21218</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> |  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2001 N. Payson Street</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>JAMES</b> MIDDLE <b>JAMES</b> LAST <b>GRIFFIN</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ROSA</b> MIDDLE <b>Griffin</b> LAST <b>Griffin</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b> <b>218-14-8102</b>   |  | 16c. INFORMANT<br><b>Mrs. Addie Griffin</b> ADDRESS<br><b>2001 N. Payson St</b><br><b>VAMC medical records, Baltimore, Maryland</b> |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic prostate CA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>urinary tract infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>185-</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>September 19, 1979</b> to <b>November 21, 1979</b> , that (we) lost<br>saw the deceased alive on <b>November 21, 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above. (we) (did) (not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Joseph A. Petrozzy</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph A. Petrozzy</b>   |  |  |  | 22e. ADDRESS<br><b>VAMC, Baltimore, Maryland 21218</b>   |  |   |  |

|   |  |                                     |  |   |  |  |  |
|---|--|-------------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>11-26-79</b>        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NAT. Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE <b>MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph L. Russ</b>         |  | ADDRESS<br><b>2222 W. North Ave</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1979</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony A. Brady</b>                          |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

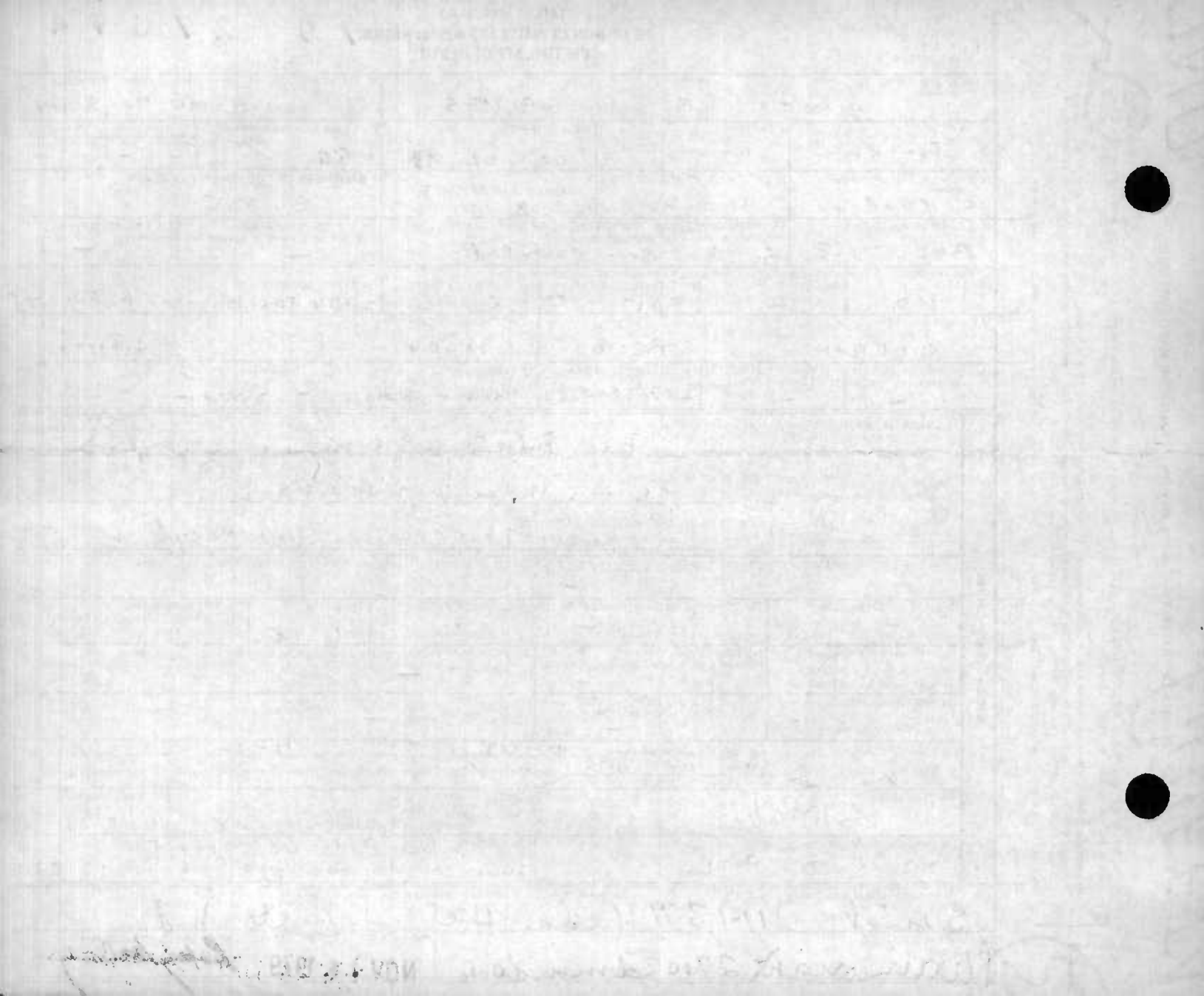
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |   |  |  |
|--|--|---|--|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 7 9 2 7 3 9 4  |   |  |   |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.   |   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>ELNORA B. GRIMES   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 10 '79  |   |  |   |  | 2b. HOUR<br>8:40AM                           |
| 3. SEX<br>Female   |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>02 02 93   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>13. City MD.  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>So. Bal. Gen. Hospital. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>—                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—  |  |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY<br>—  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2444 Joseph Ave. Bal. 21225  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>SHERMAN BROWN   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY SIMMS   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>—   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>247-38-5664   |  | 17. INFORMANT<br>Prince Nora.   |  | ADDRESS<br>— Same —   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Poss. Pul. Embolism</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lt. Leg. Hematophagocytosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recent Lt. Cerebro. Vas. Accident</u><br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br>—  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. — 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>—   |  |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> —   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>— — — — —   |  |   |  |   |  |  |
| 22a. I certify that (if this hospital) attended the deceased from <u>10-19</u> , 19 <u>79</u> , to <u>11-10</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11-10</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><u>S. D. Patel</u>   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>11/10/79  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. S. D. PATEL   |  |   |  |   | 22e. ADDRESS<br>So. Bal. Gen. Hosp.<br>3001. S. Hanover St. Bal. Md. 21230   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11-13-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wainwright  |  |   |  |   | ADDRESS<br>2700 Edmondson  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1979 |   | 25b. REGISTRAR'S SIGNATURE<br>H. J. McCreedy |  |

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 7 9 2 7 3 9 5  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a DATE OF DEATH   |  |   |  |
| FIRST MIDDLE LAST<br>IRA S. Grimes  |  |  |  | MONTH DAY YEAR HOUR<br>Nov. 19, 1979 559 AM  |  |   |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  |
| male  |  | Black  |  | Mar. 15, 1907  |  | 72 YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Virginia  |  | U.S.   |  |  |  | Baltimore City MD.  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| Baltimore   |  | Providence Hosp  |  | Housekeeper  |  | Produce   |  |
| 13a STATE   |  |  |  | 13b COUNTY   |  |   |  |
| Md  |  |  |  | Baltimore  |  |   |  |
| 14 FATHER'S NAME (FIRST MIDDLE LAST)  |  |  |  | 15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)  |  |   |  |
| Peter Grimes  |  |  |  | Sarah Webster  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b SOCIAL SECURITY NO   |  |   |  |
| No  |  |  |  | 224-42-2204  |  |   |  |
| 17 INFORMANT  |  |  |  | ADDRESS  |  |   |  |
| Emily Carter  |  |  |  | -4323 Elderson Ave   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Arrest   |  |  |  |  |  |   |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrhythmia  |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Atherosclerotic Cardiovascular Disease  |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Brain Syndrome Disease   |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?  |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b SIGNATURE Robert L. Wan   |  |  |  | DEGREE   |  | 22c DATE SIGNED 11/20/79  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT WAN   |  |  |  | 22e ADDRESS 40 PROUDENT HOSPITAL   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION CITY OR TOWN COUNTY STATE  |  |
| Burial  |  | 11/24/79   |  | Grimes Family Cem.   |  | Kilmer, Virginia  |  |
| 24a FUNERAL DIRECTOR  |  |  |  | 24b DATE REC'D. BY REGISTRAR   |  | 24c REGISTRAR'S SIGNATURE   |  |
| VERNON R. BAILEY FUNERAL HOME, 1348 N. CALHOUN  |  |  |  | NOV 27 1979  |  | [Signature]   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORM PA. 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |   |  |  |  |   |  | 9 27396   |  |
|--|---------|--|--|---|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |         | REG. NO.   |  |   |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE KNOWN<br>OF DEATH  |  | 2b. HOUR  |  |
| PAUL   |         | G.   |  | GRIPPO  |  |  |  | ESTIMATED <input checked="" type="checkbox"/> 11 15 19 79           |  | M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 24 HRS.   |  | 2c. DATE<br>PRONOUNCED<br>DEAD                                      |  | 2d. HOUR  |  |
| male   | white   | August 31, 1958  |  | 21 YRS.   |  |  |  | 11 15 19 79   |  | 10:08 p M                                       |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |   |  |   |  |
| New Jersey   |         | U.S.A.   |  | Baltimore City MD.  |  |  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |   |  |
| Baltimore  |         | University Hospital  |  |   |  | Student  |  | Loyola College  |  |   |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |   |  |
| New Jersey   |         | Middlesex  |  | Middlesex   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 11 Weiss Drive  |  |   |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |   |  |   |  |
| FRANK  |         | EVA  |  |   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |   |  |   |  |
| No   |         | 145-42-8446  |  | MR. FRANK GRIPPO  |  | 11 Weiss Drive<br>Middlesex, N.J.                                |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries with complications<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |         |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY?  |  |   |  |
|  |         |  |  |   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |   |  |
| 12:32x 10-30-19 79   |         | Driver in auto/fixed object impact.  |  |   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY  |  | STATE   |  |
|  |         | road   |  | York Rd. nr. Roberts Rd.  |  | Balto.   |  | Md.   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |  |  |   |  |   |  |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)<br>M.D. Deputy Chief   |  |   |  |  |  | DATE<br>SIGNED  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  |   |  |  |  |   |  |   |  |
| Thomas D. Smith, M.D.  |         | 111 Penn St.   |  |   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                    |  |   |  |   |  |
| BURIAL   |         | 11-21-1979   |  | RESURRECTION  |  | PISCOTAWAY, N.J.   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                       |  |   |  |   |  |
| Walter Conklin   |         | 5444 BELAIR Rd. BALTO. Md  |  | NOV 20 1979   |  | [Signature]  |  |   |  |   |  |

MEDICAL CERTIFICATION

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or official communication.]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Roseannette Grogg</b>  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 4, 1979</b>   |  | 2b HOUR<br><b>7 P.</b>   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 14, 1913</b>  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  | MD.   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2809 Roselawn Avenue</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Waitress</b>   |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |  |   |  |  |  |
| 13a STATE<br><b>Md.</b>   |  | 13b COUNTY  |  | 13c CITY OR TOWN<br><b>Balto</b>   |  |
| 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS<br><b>2809 Roselawn Avenue</b>   |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Raymond</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Theresa Lazzara</b>  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-14-8442</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Maurice Grogg (husband) same address</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic liposarcoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |  |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |
| 19a DATE OF OPERATION<br><b>-</b>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9/21 1979</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>9/21 1979</b> to <b>11/4 1979</b> , that (I) (we) last saw the deceased alive on <b>10/4 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b SIGNATURE<br><b>Dr. Davis M. Hahn</b>   |  | DEGREE<br><b>MD</b>   |  | 22c DATE SIGNED<br><b>11/7/79</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Davis Hahn</b>   |  | 22e ADDRESS<br><b>Good Samaritan Hosp</b>   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>11/8/79</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md.</b>   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR<br><b>Schimmunek Funeral Home, Inc.</b>   |  | ADDRESS<br><b>3331 Brehms Lane Balto. Md. 21213</b>   |  | DATE REC'D BY REGISTRAR<br><b>NOV 7 1979</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 7 9 2 7 3 9 8   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William Elmer Gross   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-20-79   |  | 2b. HOUR<br>7 <sup>35</sup> P <sup>M</sup>   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9-20-10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br>Sales Supervisor  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bakery  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13b. STREET ADDRESS<br>1104 Newfield Rd. 21207   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Woodlawn   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William H. Gross   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Brady   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>212-10-6429A  |  | 17. INFORMANT<br>ADDRESS<br>21220   |  | William E. Gross, 652 West Kingsway  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MYOCARDIAL INFARCTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>STROKE</u> |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-21</u> , 19 <u>79</u> , to <u>11-20</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>10-20</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                            |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11-20-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MALHOTRA  |  |   |  | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/24/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR 1630 Edmondson Ave. Catonsville, Md.<br>NAME ADDRESS<br>Witzke Funeral Home of Catonsville, P.A. 21228  |  |   |  | 25a. DATE REC'D BY REGISTRAR<br>NOV 23 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

300 CATON AVE. BALTIMORE, M. 21201

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BALTIMORE ST. AGNES HOSPITAL  
BALTIMORE CITY

11-20-68  
11-20-68  
11-20-68



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |         |  |  |   |  |   |  |                                      |  |                          |       |   |  |          |
|--|---------|--|--|---|--|---|--|--------------------------------------|--|--------------------------|-------|---|--|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH                    |  | KNOWN<br>ESTIMATED       | MONTH | DAY   | YEAR   | 2b. HOUR |
| Paul   |         | Guercio  |  |   |  |   |  | 11                                   |  | 28                       | 19    | 79  | M  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD |       | MONTH   | DAY  | YEAR     |
| male   | white   | 2 14 1888  |  | 91 YRS.   |  |   |  |                                      |  | 11                       |       | 28  | 19   | 79       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                          |       |   |  | MD.      |
| Italy  |         | U.S.A.   |  |   |  |   |  | Baltimore City                       |  |                          |       |   |  |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |                          |       |   |  |          |
| Baltimore  |         | 2100 Harmon Avenue   |  | Barber  |  | Self-employed   |  |                                      |  |                          |       |   |  |          |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |                          |       |   |  |          |
| Maryland   |         | ---  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2100 Harman Ave., 21230              |  |                          |       |   |  |          |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                      |  |                          |       |   |  |          |
| Joe  |         | Guercio  |  | Josephine   |  | Unknown   |  |                                      |  |                          |       |   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                      |  |                          |       |   |  |          |
| No   |         | 217-32-9497A   |  | John Guercio  |  | 2100 Harman Ave.  |  |                                      |  |                          |       |   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |                                      |  |                          |       |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |   |  |                                      |  |                          |       |   |  |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |                                      |  |                          |       | 20. AUTOPSY?  |  |          |
|  |         |  |  |   |  |   |  |                                      |  |                          |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |   |  |                                      |  |                          |       |   |  |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |   |  |                                      |  |                          |       |   |  |          |
|  |         |  |  |   |  |   |  |                                      |  |                          |       |   |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |                                      |  |                          |       |   |  |          |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |  | DATE SIGNED   |  |   |  |                                      |  |                          |       |   |  |          |
| Hormez R. Guard, M.D.  |         | Assistant  |  | 11/28/79  |  |   |  |                                      |  |                          |       |   |  |          |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  |   |  |   |  |                                      |  |                          |       |   |  |          |
| Hormez R. Guard, M.D.  |         | 111 Penn Street, Balto., MD 21201  |  |   |  |   |  |                                      |  |                          |       |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                                      |  |                          |       |   |  |          |
| Burial   |         | 12/1/79  |  | New Cathdral Cemetery   |  | Baltimore City Md.  |  |                                      |  |                          |       |   |  |          |
| 24. FUNERAL DIRECTOR<br>NAME   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                      |  |                          |       |   |  |          |
| Hubbard Funeral Home   |         | 4107 Wilkens Ave.  |  | NOV 30 1979   |  |   |  |                                      |  |                          |       |   |  |          |



TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |  |   |   |                                  |
|--|---|--|---|---|----------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles Marshall GUNTHER</b>            |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 29 1979</b>  |   | 2b HOUR<br><b>10:15 AM</b>  |                                  |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 20, 1905</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b><br>YRS. MONTHS DAYS HOURS MIN.                      |                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |                                  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Decorator</b> |   | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>Md.</b>   |   | 13b COUNTY   | 13c CITY OR TOWN<br><b>Baltimore</b>  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph A. Gunther</b>                |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Regina E. Dumler</b>  |   |   |                                  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b> |   | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>219-10-7845</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>Baldwin, Md.</b><br><b>Mr. Cyril L. Gunther 13105 Sanfield Rd</b> |                                  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost

(b) **Carcinoma Of Left Lung With Metastasis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Left Bronchopleural Fistula**

|   |   |  |   |
|---|---|--|---|
| 19a DATE OF OPERATION<br><b>11-8-79</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma Of Left Lung</b> | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (if this hospital) attended the deceased from <b>October 22</b> , 19 <b>79</b> , to <b>November 29</b> , 19 <b>79</b> , that <b>we</b> last<br>saw the deceased alive on <b>November 29</b> , 19 <b>79</b> , and that in <b>our</b> opinion death occurred on the date and hour and from the causes stated<br>above <b>(we)</b> (did) (do not) view the body after death. |   |  |   |
| 22b. SIGNATURE<br><b>S. Talaie</b>  | DEGREE<br><b>M.D.</b>   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>11/29/79</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Saied Talaie, M.D.</b>  |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |   |

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                   | 23b. DATE<br><b>Dec. 1, 1979</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b> |                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1979</b>        | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-11-73

November 29 1973 10 123

Bellevue City

Bellevue  
Marling General Hospital

Carcinoma of Lung with Metastasis

Carcinoma of Lung with Metastasis

Lung Bronchogenic Carcinoma

11-11-73  
Carcinoma of Lung with

November 29 1973 10 123  
November 29 1973 10 123

Bellevue, N.D.  
Marling General Hospital

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 27401

|  |  |  |   |   |  |  |  |   |  |  |
|--|--|--|---|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Fanny Guss</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 19 79</b>                |   |  | 2b. HOUR<br><b>8 30 PM</b>   |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 1 1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>8 30</b>       |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SWITZERLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b> |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS)<br>STATE<br><b>MD</b> |  |  | 13b. COUNTY<br><b>BALTIMORE</b>                                       |   |  | 13c. CITY OR TOWN<br><b>OWINGS MILLS</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CALMAN JACOBWITZ</b>                                      |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FLOTA UNKNOWN</b> |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  |   |  |  |
| 17a. SOCIAL SECURITY NO.<br><b>213-10-9939B</b>  |  |  | 17b. INFORMANT<br><b>MR. SIDNEY TOBY</b>                              |   |  | 17c. ADDRESS<br><b>6507 COPPER RIDGE DR., APT. 101 #21209</b>  |  |   |  |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac and Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis - shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I) (a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-18</b> , 19 <b>79</b> , to <b>11-19</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11-19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Samy Bebauxy MD</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11-19-79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMY Bebauxy</b>  |  |  |  | 22e. ADDRESS<br><b>Sinai Hosp. of Baltimore.</b>                                     |  |   |  |

|  |  |                                   |  |   |  |   |  |
|--|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>NOV. 21, 1979</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW YOUNG MEN</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1979</b>           |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Helms</b>                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RETURNED TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

|  |  |  |  |   |  |  |  |   |  |          |  |           |  |
|--|--|--|--|---|--|--|--|---|--|----------|--|-----------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |   |  | 7 9      |  | 2 7 4 0 2 |  |
| FOR<br>STATE<br>REGISTRAR  |  |  |  |   |  |  |  |   |  | REG. NO. |  |           |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Robert Edward Gutermuth</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 79</b>                                       |  | 2b. HOUR<br><b>12:00 AM</b>   |  |          |  |           |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 19 77</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>3 wks.</b> YRS MONTHS DAYS<br><b>0 25</b>              |  | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |          |  |           |  |
| 7b. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.                                |  |   |  |          |  |           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. Maryland hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>(Parents address)</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |          |  |           |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Johns</b>  |  | 13c. CITY OR TOWN<br><b>Balt.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 13e. STREET ADDRESS<br><b>201 West End Ave.</b>   |  |          |  |           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Gutermuth</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Wendy Cambridge Md. Lewis</b>   |  |  |  |   |  |          |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br><b>Robert Gutermuth, 201 West End Ave.</b><br><b>xxxxxxx</b>   |  |  |  |   |  |          |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure (R.V.)</b><br><b>7452</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Tetral of Fallot</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Potential Connection</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |   |  |          |  |           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Sp. Total Connection (Renal failure +/- Sepsis)</b>   |  |  |  |   |  |  |  |   |  |          |  |           |  |
| 19a. DATE OF OPERATION<br><b>11/2</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Tetral. Fallot</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  |           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |          |  |           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b>  |  |  |  |   |  |          |  |           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/13/79</b> to <b>11/13/79</b> , that (I) (we) last saw the deceased alive on <b>11/13/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                    |  |  |  |   |  |  |  |   |  |          |  |           |  |
| 22b. SIGNATURE<br><b>W. W. Scott</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>11/13/79</b>   |  |          |  |           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. W. Scott</b>  |  |  |  | 22e. ADDRESS<br><b>225 Greene St. Balt. Md.</b>   |  |  |  |   |  |          |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>   |  | 23b. DATE<br><b>11/16/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Our Lady of Good Council, Secretary, Dor.,</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b>                               |  |   |  |          |  |           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Curran Funeral Home, 308 High St., Cambridge, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony A. Brady</b>  |  |   |  |          |  |           |  |





Robert Edward

Robert Edward, 201 West 4th Ave.

Funeral Home, 201 West 4th Ave.,  
Cambridge, Mass.  
12/16/39  
Our lady of Good Counsel, Secretary, etc.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |  |  |  |   |  |
|---|--|---|---|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Florence G. Guthrie  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 16, 1979  |  |  | 2b. HOUR<br>3:10 M   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 23, 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4314 Woodlea Ave. |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Candy Store         |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>Maryland  |  |   |   |   | 13b. COUNTY<br>--  |  | 13c. CITY OR TOWN<br>Baltimore                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Henry Blatchley   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lavinia Mc Cauley  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>216-28-1946                             |   | 17. INFORMANT ADDRESS<br>Mr. William S. Shusta, 4314 Woodlea Ave.  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive C-V Disease</u><br>4029<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this <del>person</del> ) attended the deceased from Jan 19 79 to Nov 16 19 79, that (I) (we) saw the deceased alive on Nov 3 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br>William S. Fusting, M.D.  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>11-19-79   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William Fusting, M.D.  |  |   |   |   | 22e. ADDRESS<br>300 Ridgely Road Timonium, Maryland  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>11/20/1979   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon National  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J. Ruck, Inc.  |  |   |   |   | 5305 Harford Road<br>ADDRESS<br>Baltimore, Maryland  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1979                   |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. Ruck  |  |



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Item #2a Film G537 11/21/79 re

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

7 9

2 7 4 0 4

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM J. HAASE</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/11/79 Nov. 10, 1979</b>   |  | 2b. HOUR<br>M  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 9, 1910</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor U.S. Coast Guard</b>                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sheet Metal</b>                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>4204 Woodstock Ave</b>                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. Haase</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Theresa Nunberger</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-03-2504</b>   | 17. INFORMANT ADDRESS<br><b>Mrs Lydia E Haase Same</b>   |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1629 Metastatic Oat Cell CA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Davis M. Hahn</b>   |   | DEGREE<br><b>MD</b>   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>11/10/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Davis M. Hahn</b>  |   | 22e. ADDRESS<br><b>5601 Loch Raven Blvd.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   | 23b. DATE<br><b>11/14/79</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1979</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>                                 |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



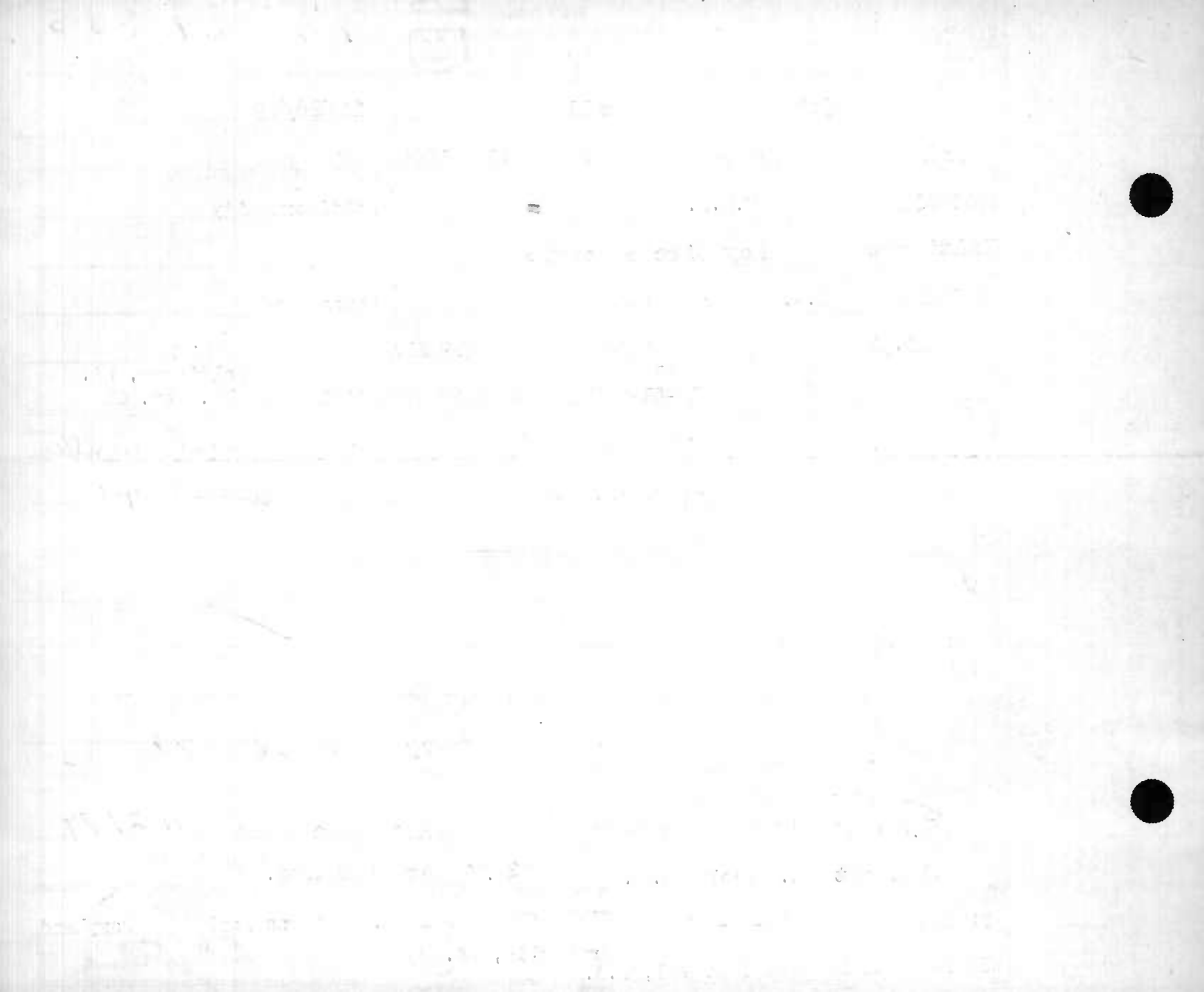
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 7 9 27 405   |   |
|--|--|--|--|--|---|
| 1 - FOR STATE REGISTRAR  |  |  |  | REG. NO.   |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Elijah Hall</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/26/79</b>            |  | 2b HOUR<br>M  |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>Negro</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 21 1896</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Key Circle Hospice</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>A.A.</b>  | 13c CITY OR TOWN<br><b>SEVERNA PARK</b>                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           | 13e STREET ADDRESS<br><b>Manns Road</b>   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ELIJAH HALL</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>OPHELIA GREEN</b>  |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b SOCIAL SECURITY NO.<br><b>218-DD-0343A</b>   |  | 17 INFORMANT<br>ADDRESS <b>Baltimore, Md.</b><br><b>ELIZABETH HALL 1701 Eutaw Pl. Apt. 901</b> |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malnutrition</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>AS CVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>several months</b><br><b>several yrs</b>                                 |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                 |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-9-79</b> to <b>11-26-79</b> , that (I) (we) last saw the deceased alive on <b>11-26-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b SIGNATURE<br><b>Ellsworth Cook</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11-27-79</b>  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ellsworth E. Cook M.D.</b>  |  | 22e ADDRESS<br><b>2431 Maryland Ave.</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>11-30-1979</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ASBURY TOWN NECK CEME.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Severna Park Maryland</b>                     |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>  |  | ADDRESS<br><b>Annapolis, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1979</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Barbara McCurdy</i>  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |  |   |  |
|---|--|--|--|---|--|---|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  |   | 7 9 2 7 4 0 6<br>REG. NO.                                      |   |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HESTER</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 12 1979</b> |   |   |  |   | 2b. HOUR<br><b>6:20 PM</b>                     |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 22 1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>    |   | 7. IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balt.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY                  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  |  |  |   | 13b. COUNTY<br><b>U. S.</b>                                    |   | 13c. CITY OR TOWN<br><b>BALTO</b>                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PETER</b>   |  |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MATTIE</b>  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>N/O</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-09-6597</b>                 |   | 17 INFORMANT<br>ADDRESS<br><b>ARTURO Brown 1112 Mcalleen Ct</b> |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>5601</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia and Aspiration</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 minutes</b> |  |  |  |   |  |   |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Severe cerebrovascular disease and brain damage</b>  |  |  |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NONE</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>N/A</b>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>N/A</b> 19 <b>79</b>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b>   |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>OR WHILE <input type="checkbox"/> AT WORK<br><b>N/A</b>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b>   |  | 21f. LOCATION<br>STREET<br><b>N/A</b>   |  | CITY OR TOWN  |   | COUNTY   |   | STATE  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1, 1979</b> , 19 <b>79</b> , to <b>Nov. 11</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov. 11</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Roderick D. Woods</b> MD   |  |  |  |   | DEGREE<br><b>MD</b>  |   |   | 22c. DATE SIGNED<br><b>11-11-79</b>                |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Roderick Woods, MD</b>  |  |  |  |   | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov 15, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Bm. Crutched C. 24</b>  |   | COUNTY   |   | STATE  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Locks Funeral Home</b>  |  |  |  | ADDRESS<br><b>1304 N. Central Ave</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Harry McBrady</b> |   |  |





NOV 14 1979



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 2 7 4 0 7  |  |   |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Henry S. HALLER   |  |  |  |   |  |  |  | 11 21 79  |  | 12:15A M                                     |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 UNDER 1 YEAR MONTHS DAYS  |  | 7 UNDER 24 HRS HOURS MIN                     |  |
| Male  |  | White  |  | Oct. 27, 1899   |  | 80   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Pennsylvania  |  | USA  |  |   |  | Baltimore City MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore   |  | Church Hospital  |  |   |  | Adm. Asst.   |  | Paul's Church Old St.   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland  |  |  |  | Baltimore   |  |  |  | 309 Cathedral Street  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |  |   |  |  |  |
| Unknown   |  | Unknown  |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT ADDRESS   |  |  |  |   |  |  |  |
| No  |  | 413 30 3077  |  | Rev. Halsey Cook  |  | Balto., Md.  |  |   |  |  |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u>   |  |  |  |   |  |  |  |   |  |  |  |
| 185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF THE PROSTATE GLAND</u>  |  |  |  |   |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-30</u> 19 <u>79</u> , to <u>11-21</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-21</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE <u>Dr. Walker Impagliatelli</u>  |  |  |  | DEGREE  |  |  |  | 22c. DATE SIGNED <u>11-21-79</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. WALKER IMPAGLIATELLI M.D.</u>  |  |  |  | 22e. ADDRESS <u>CHURCH HOSPITAL CORPORATION 21231 100 NORTH BROADWAY, BALTIMORE, MARYLAND</u>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Cremation   |  | 11/23/79   |  | Greenmount  |  | Baltimore, Md.   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <u>Henry W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Road Balto., Md. 21212</u>  |  |  |  | 25. DATE REC'D. BY REGISTRAR <u>NOV 23 1979</u>   |  | 25b. REGISTRAR SIGNATURE <u>[Signature]</u>  |  |   |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|  |  |  |  |   |   |   |   |   |  |
|--|--|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RITA ELENORA HAMILTON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/17/79</b>                             |   |   | 2b. HOUR<br><b>10:30A</b>   |   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 6 31</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>U of Md 72 S. Greene St.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>4142 Hyden Ct</b> |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Balt</b>   |  | 13c. CITY OR TOWN   |   |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Compton</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SOPHIA J. Olase</b>   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>21 726 6306</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Christiansburg, Va. 24073</b><br><b>Mrs. Karen Shelor P.O. Box 482</b>                                     |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br><b>1602</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Step II recurrent squamous CA @ maxillary sinus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>11/16/79</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Sinusitis &amp; abscess</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11/2</b> , 19 <b>79</b> , to <b>11/17</b> , 19 <b>79</b> , that (1) (we) lost<br>saw the deceased alive on <b>11/17</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>WAC Moore</b>   |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/17/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MOORE</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>U of Md Balt Md 21201</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11/20/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery Brooklyn A.A. Md.</b>              |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George J. Gonce 4001 Ritchie Hgwy Balto 21225</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Ruby H. H. H.</b>  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



RECEIVED

ST. LOUIS, MO. 63102

11/20/72  
ST. LOUIS, MO. 63102  
ST. LOUIS, MO. 63102

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE E. LAST HAMMOND |  |  | 2a. DATE OF DEATH<br>MONTH 11 DAY 20 YEAR 79 |  |  | 2b. HOUR<br>8:05 A.M.                                    |  |
| 3 SEX<br>F   |  | 4 RACE<br>B  |  | 5. DATE OF BIRTH<br>MONTH 03 DAY 29 YEAR 87  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>92                     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U. OF MARYLAND HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |

|  |  |  |  |  |                                |   |   |  |   |  |
|--|--|--|--|--|--------------------------------|---|---|--|---|--|
| 13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>BALTIMORE                                     |  | 13c. CITY OR TOWN<br>BALTIMORE |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1068 W. FAYETTE ST |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Napoleon Jackson                  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elzina Bryan |  |                                |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)      |  |                                | 17 INFORMANT<br>DOROTHY A. NELSON 241 N. Schreiber St |   |  |   |  |

|  |  |  |  |
|--|--|--|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>486-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PNEUMONIA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
Atherosclerotic CARDIOVASCULAR DISEASE, AORTIC INSUFFICIENCY

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |

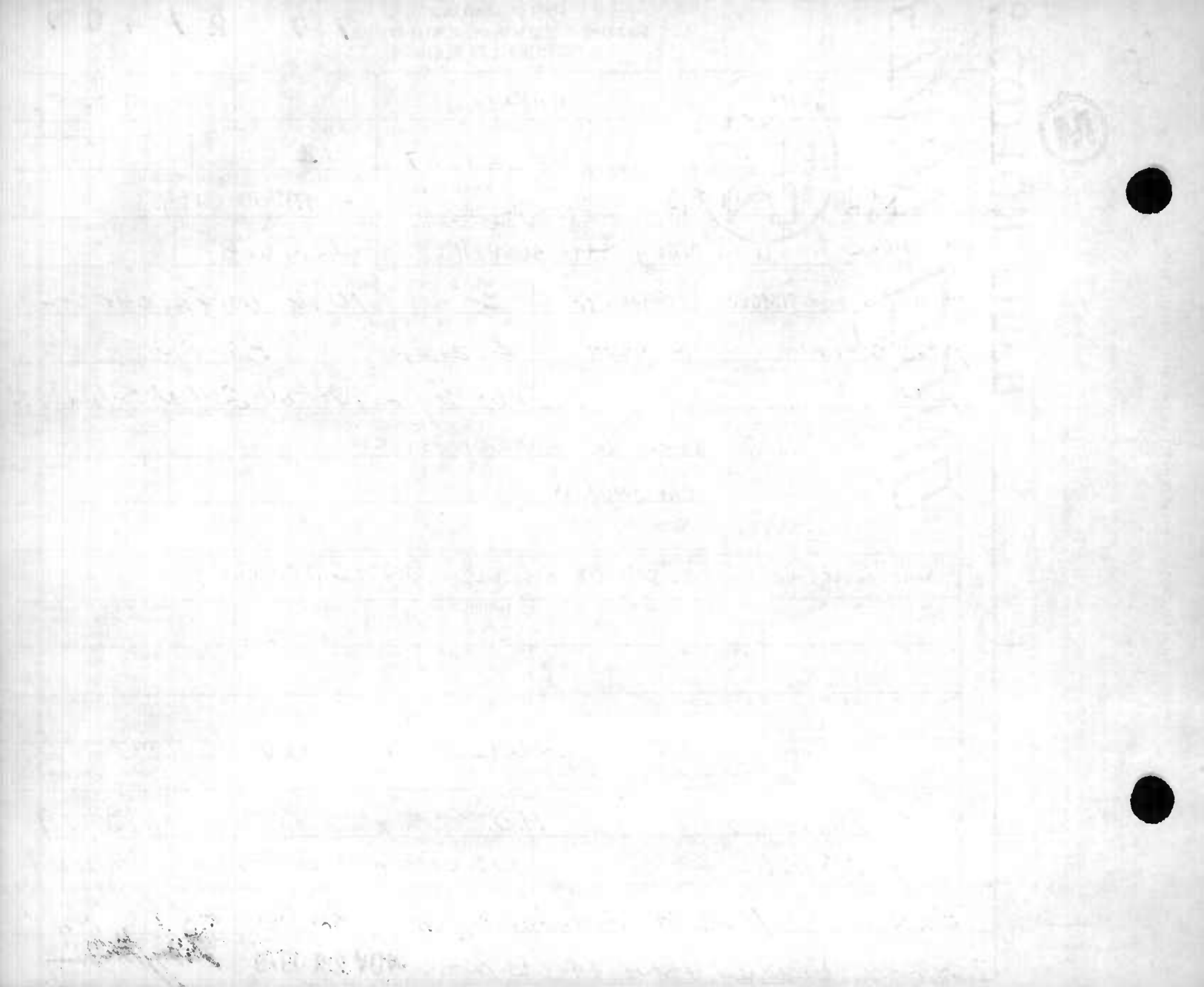
|  |  |  |  |                |  |  |  |                              |  |
|--|--|--|--|----------------|--|--|--|------------------------------|--|
| 22a. I certify that (1) (his hospital) attended the deceased from JULY 19 79 to NOV 19 79. that (1) (we) lost saw the deceased alive on NOV 20 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>L. Gaynes                        |  | DEGREE<br>M.D. |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/20/79 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. GAYNES   |  | 22e. ADDRESS<br>225. Greene St Baltimore, Maryland |  |                |  |  |  |                              |  |

|   |  |                         |  |  |  |   |  |
|---|--|-------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>11-26-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARbutus Mem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BA MD |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ISAIAH L. BRIDWELL 450R |  | ADDRESS<br>1913 W. BOLL |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1979       |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

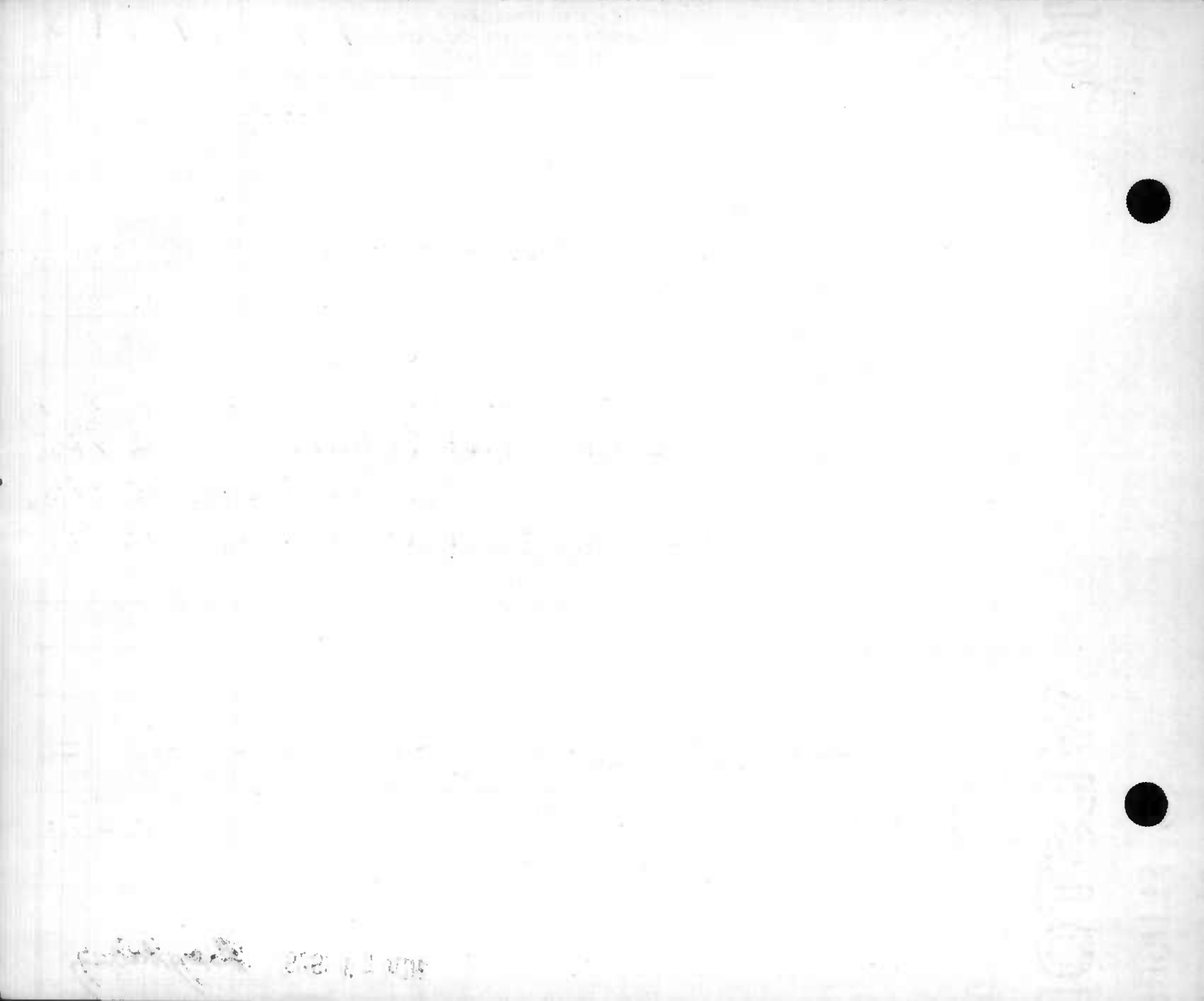


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   | 79 27410   |  |   |  |                          |
|---|--|--|---|---|--|--|---|--|--------------------------|
| 1. FOR STATE REGISTRAR  |  |  |   |   | REG. NO.   |  |   |  |                          |
| 1. DECEASED NAME (TYPE OR PRINT) <b>HANS HANAUER</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOV. 14, 1979</b>       |  |   |  | 2b. HOUR<br><b>6 P</b> M |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>NOV. 10, 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD.   |   |  |                          |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2853 W. COLD SPRING LA. (21215)</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELECTRICIAN</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ELECTRICAL CONTR</b>   |                          |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>2853 W. COLD SPRING LA. (21215)</b>  |                          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>FERDINAND HANAUER</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |   |  |                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>105-16-9491</b>                 |  | 17. INFORMANT ADDRESS<br><b>MRS. RUTH HANAUER 2853 W. COLD SPRING LA.</b> |  |                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pul. Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b>   |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 YRS.</b><br><b>15 YRS.</b><br><b>10 YRS.</b>                          |                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |  |   |  |                          |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-2</b> , 19 <b>79</b> , to <b>11-14</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11-12</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |  |                          |
| 22b. SIGNATURE DEGREE<br><b>Charles Angell, M.D. per Barnett</b>  |  |  |   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11-15-79</b>  |                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARNETT BERMAN, M.D.</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>611 PARK AVE.</b>   |   |  |                          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>11/16/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD.</b>          |  |                          |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS</b>   |  |  |   |   |  | 6010 ADDRESS<br><b>REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1979</b>  |                          |
|   |  |  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Brady</b>   |   |  |                          |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 18.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 7 9 2 7 4 1 1   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 2. DECEASED NAME (TYPE OR PRINT) <b>ULYSSES P. HANCOCK</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 4 1979</b>   |  | 2b. HOUR <b>9:50P</b>   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>12 20 1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Hancock</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hanna Nivens</b>   |  | 13e. STREET ADDRESS <b>1880 East Fayette Street</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>250-28-7558</b>  |  | 17. INFORMANT ADDRESS <b>Estella Hancock 1880 East Fayette Street</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>436-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBRO-VASCULAR ACCIDENT</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Arthur Ruxo MD</b> DEGREE   |  |  |  | 22c. DATE SIGNED <b>11/4/79</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR RUXO</b>  |  |
| 22e. ADDRESS <b>601 N. BROADWAY</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>11/9/1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 East North Avenue</b> ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 6 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |

11.11

NOVEMBER 11 1911

WEDNESDAY

BALTIMORE CITY

MISS MARY H. HARRIS

1259A - 11.11.11

1259A - 11.11.11

11/11/11

MISS MARY H. HARRIS

1259A - 11.11.11

11/11/11

MISS MARY H. HARRIS

1259A - 11.11.11

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |        |   |   |   |  |   |
|--|--|---|--------|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>James  | MIDDLE | LAST<br>Hanks   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-7-79                               |   | 2b. HOUR<br>5 40 AM  |   |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |        | 5. DATE OF BIRTH MONTH DAY YEAR<br>04 29 1911   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |        |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chef                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>V.a. Hosp. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |        | 13b. COUNTY<br>Baltimore  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George H. Hanks   |  |   |        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Dora D. Dyson   |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.II   |        | 17. INFORMANT ADDRESS<br>Mrs. Katherine L. Hanks 2216 Ashburton Street  |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |        |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |        |   |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-4-79 to 11-7-79, that (I/we) lost saw the deceased alive on 11-7-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |        |   |   |   |  |   |
| 22b. SIGNATURE<br>H Devadoss   |  |   |        | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |   |   |  | 22c. DATE SIGNED<br>11-7-79                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. Devadoss   |  |   |        | 22e. ADDRESS<br>Provident Hospital  |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11-9-79  |        | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. Maryland                            |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Herbert E. Nutter 3035 W. North Ave.   |  |   |        | 25a. DATE REC'D. BY REGISTRAR<br>NOV 8 1979   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |               |   |   |   |                               |  |  |  |   | 9 27413<br>REG. NO.  |                                   |  |
|--|---------------|---|---|---|-------------------------------|--|--|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR   |               |   |   |   |                               |  |  |  |   | 2a. DATE OF DEATH KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <input type="checkbox"/> 11 10 19 79 |                                   | 2b. HOUR M 79  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Carl Walter Harms  |               |   |   |   |                               |  |  |  |   | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 10 19 79  |                                   | 2d. HOUR P.M. 11:48  |
| 3. SEX male  | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 03 22 03                    | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS   | 8. IF UNDER 24 HRS. HOURS MIN | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                          |   |  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany  |               | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                         |   | 10. CITY OR TOWN OF DEATH Baltimore   |                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Opti. Inst. Maker |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE Maryland  |               |   |   |   |                               |  |  |  |   | 13b. COUNTY Baltimore  |                                   | 13c. CITY OR TOWN Lansdowne                                  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carl W. Harms  |               |   |   |   |                               |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Gohlert  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No  |               |   |   |   |                               |  |  |  |   | 16b. SOCIAL SECURITY NO. 212-07-5301   |                                   | 17. INFORMANT ADDRESS Anna M. Harms, 327 Fifth Avenue, 21227 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF   |               |   |   |   |                               |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |               |   |   |   |                               |  |  |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |                               |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |               | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                               |  |  |  |   |  |                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                               |  |  |  |   |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |               |   |   |   |                               |  |  |  |   |  |                                   |  |
| ACTUAL SIGNATURE <i>H.R. Guard</i>   |               | TITLE (SPECIFY) Assistant                                   |   | M.D. MEDICAL EXAMINER   |                               | DATE SIGNED 11/11/79   |  |  |   |  |                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.  |               | ADDRESS 111 Penn Street, Balto. MD                          |   |   |                               |  |  |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |               | 23b. DATE 11-14-79  |   | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery                          |                               | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland  |  |  |   |  |                                   |  |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,  |               | ADDRESS 4107 Wilkens Ave.                                   |   | 25a. DATE REC'D. BY REGISTRAR NOV 13 1979                                     |                               | 25b. REGISTRAR'S SIGNATURE <i>L. J. Belmont</i>  |  |  |   |  |                                   |  |

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |  |
|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>ANNIE B. HARRIS  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-15-79   |  | 2b. HOUR<br>10:10 P.M.                       |
| 3. SEX<br>Female   | 4. RACE<br>Black   | 5. DATE OF BIRTH MONTH DAY YEAR<br>7-28-35   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>44 YRS.   |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   | 7c. CITIZEN OF WHAT COUNTRY?<br>U.S.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MD.  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>BON SECOURS Hosp. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>Md.  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            | 13e. STREET ADDRESS<br>1732 W. PRATT ST.     |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Vesce   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Kochel Epps  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>231-44378  |  |  |
| 17. INFORMANT ADDRESS<br>Debra Owens - 105 Poplar Grove St.  |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular C. Disease</u> 248<br>DUE TO OR AS A CONSEQUENCE OF <u>Myocardial infarction, malnutrition</u><br>DUE TO OR AS A CONSEQUENCE OF <u>Retrovirus; Bilateral Pneumonia</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Diabetes Mellitus; Pancreatic Insufficiency Chronic Alcoholism</u> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>11-15, 1979</u> , to <u>11-15, 1979</u> , that (1) (we) lost saw the deceased alive on <u>11-15, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |
| 22b. SIGNATURE<br><u>William R. Law</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11-16-79                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILLIAM R. LAW, M.D.  |  | 22e. ADDRESS<br>BON SECOURS HOSPITAL<br>2000 W. BALTIMORE ST BALTO. MD   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  | 23b. DATE<br>11/20/79  | 23c. NAME OF CEMETERY OR CREMATORY<br>FAMILY CEMETERY  | 23d. LOCATION CITY OR TOWN<br>CREWE  | COUNTY<br>VA STATE                           |
| 24. FUNERAL DIRECTOR<br>WM. C. MARCH F/H, INC. 1101 E. North Avenue  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1979   |  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Brady</u>   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1944



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 7 9 27415   |  |
|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | CERTIFICATE OF DEATH  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George</b>   |  | FIRST <b>George</b> MIDDLE <b>Harris</b> LAST <b>Harris</b>                       |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>30</b> YEAR <b>79</b>  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Black</b>  |  | 5. DATE OF BIRTH MC <b>✓</b> DAY <b>1</b> YEAR <b>79</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b> |  |
| 10. CITY OR TOWN OF DEATH <b>Balto, City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Provident Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto, City</b> MD.   |  |
| 13a. STATE <b>md</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  |
| 14. FATHER'S NAME FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>?</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>?</b>             |  | 13d. INSIDE CITY LIMITS? YES <b>✓</b> NO <b>□</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>  |  | 16b. SOCIAL SECURITY NO. <b>229-07-9351</b>                                       |  | 17. INFORMANT <b>Mary Coleman</b> ADDRESS <b>2311 Roselawn</b>  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>1. Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>2. Dehydration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3. Malnutrition</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  | 5070  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |  | 20a. AUTOPSY? YES <b>□</b> NO <b>□</b>  |  |
| 21a. ACCIDENT WAS UNDERLYING <b>□</b> OR CONTRIBUTING <b>□</b> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |  |
| 21d. INJURY OCCURRED WHILE <b>□</b> AT WORK <b>□</b> NOT WHILE AT WORK <b>□</b>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>11-29</b> 19 <b>79</b> to <b>11-30</b> 19 <b>79</b> , that (I) <b>two</b> lost saw the deceased alive on <b>11-30</b> 19 <b>79</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>we</b> (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE <b>Maurice A. Allen, Jr. M.D.</b>  |  | DEGREE <b>M.D.</b>  |  | 22c. DATE SIGNED <b>11-30-79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Maurice A. Allen, Jr.</b>  |  | 22e. ADDRESS <b>Provident Hosp., Inc.</b>   |  |   |  |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>12-3-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BA Co.</b> COUNTY <b>md</b> STATE <b>md</b>                       |  |
| 24. FUNERAL DIRECTOR NAME <b>Rancy M. Wreelace</b> ADDRESS <b>-3405 W. French</b>   |  | 25. DATE RECD. BY REGISTRAR <b>DEC 14 1979</b>                                    |  | 26. SIGNATURE <b>Rancy M. Wreelace</b>  |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Kenneth G. HARRIS, Jr.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 7 79</b> |   |  | 2b. HOUR<br><b>809 P.M.</b>   |  |  |  |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 28, 1926</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dupont</b>   |  |   |  |  |  |
| 13a. STATE<br><b>Delaware</b>  |  |  |  | 13b. COUNTY<br><b>Wilmington</b>  |  | 13c. CITY OR TOWN<br><b>Wilmington</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>612 Ashford Road</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Kenneth Harris</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Oakley</b>  |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 410 30 0165</b>  |  | 17. INFORMANT<br><b>Mrs. Margaret M. Harris</b>                                       |  |  |  | ADDRESS<br><b>Same</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Post Septic shock and respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute lymphocytic leukemia in relapse</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Leukemia in relapse</b>  |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>sepsis to gram negative rods and candida</b>   |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 7, 1979</b> to <b>Nov 7, 1979</b> , that (I) (we) lost<br>saw the deceased alive on <b>Nov 7, 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Ayman Al-Ha Kim</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Nov 7 79</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ayman Al-Ha Kim</b>  |  |  |  | 22e. ADDRESS<br><b>University of Maryland - B.C.R.P.</b>  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal-Burial</b>  |  |  |  | 23b. DATE<br><b>11/10/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood Cemetery</b>                       |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Greenville, N.C.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Balto., Md. 4905 York Road</b>  |  |  |  | 24b. ADDRESS<br><b>21212</b>  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE AND EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 10a G538 12/3/79 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
|--|---------|--|--|--|--|---|--|---|--|--------------------------|--|---|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | MONTH                    |  | DAY                                     |  | YEAR |  | 2b. HOUR |  |
| Larry  |         | D.   |  | Harris,  |  | (Harry) Jr.   |  | 11  |  | 1                        |  | 19                                      |  | 79   |  | 5:40 a.  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD |  | MONTH                                   |  | DAY  |  | YEAR     |  |
| male   | black   | 7 4 1979   |  | 4 YRS.   |  | 4 MONTHS  |  | DAYS  |  | 11                       |  | 1                                       |  | 19   |  | 79       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                          |  |   |  |      |  |          |  |
| Maryland   |         | U. S. A.   |  |  |  | Baltimore city  |  |   |  |                          |  |   |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                          |  |   |  |      |  |          |  |
| Baltimore  |         | Provident Hospital                                       |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                          |  |   |  |      |  |          |  |
| Maryland   |         | BALTIMORE  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2408 Callow Avenue  |  |                          |  |   |  |      |  |          |  |
| 14. FATHER'S NAME  |         |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| Larry D. Harris, Sr.   |         |  |  | Barbara Ann Thomas   |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |  |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT   |  |                          |  | ADDRESS                                 |  |      |  |          |  |
|  |         |  |  |  |  |   |  | Barbara Thomas  |  |                          |  | 2408 Callow Avenue                      |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| PART I DEATH WAS CAUSED BY: <u>Sudden Infant Death Syndrome</u> <u>Bronchopneumonia</u>  |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| IMMEDIATE CAUSE (a) <u>485-</u> DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> .  |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| (c)  |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
|  |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) |  |                          |  |   |  |      |  |          |  |
|  |         |  |  | P.M. 19  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION STREET  |  |                          |  | CITY OR TOWN COUNTY STATE               |  |      |  |          |  |
|  |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)  |  |   |  | DATE SIGNED   |  |                          |  |   |  |      |  |          |  |
| <u>Margie Bre Kneel</u>  |         |  |  | Assistant  |  |   |  | 11/1/79   |  |                          |  |   |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| Margarita A. Korell, M.D.  |         |  |  | 111 Penn Street, Balto., MD 21201  |  |   |  |   |  |                          |  |   |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |      |  |          |  |
| Burial   |         |  |  | 11/5/1979  |  |   |  | King Memorial Park  |  |                          |  | Baltimore Co., Maryland                 |  |      |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |         |  |  | ADDRESS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |                          |  | 25b. REGISTRAR'S SIGNATURE              |  |      |  |          |  |
| Wm. C. March F/H   |         |  |  | 1101 East North Ave.   |  |   |  | NOV 2 1979  |  |                          |  | <u>Harry K. Kneel</u>                   |  |      |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |   |   |   |                                   |  |
|---|--|--|--|---|---|---|---|-----------------------------------|--|
| FOR<br>1 - STATE REGISTRAR  |  |  |  |   | 7 9 2 7 4 1 8<br>CERTIFICATE OF DEATH   |   |   |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR  |   |   |                                   |  |
| FIRST MIDDLE LAST<br>LUISE KRAUS HARRIS   |  |  |  |   | 2b. HOUR<br>8 49 P.M.   |   |   |                                   |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |   | 6 AGE (IN YEARS LAST BIRTHDAY)                                  |   | IF UNDER 1 YEAR MONTHS DAYS       |  |
| Female  |  | White  |  | NOV 21 1896   |   | 82 YRS  |   |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                             |   |                                   |  |
| MARYLAND  |  | USA  |  |   |   | Baltimore MD.   |   |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION (NATURE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore   |  | Mercy Hospital   |  |   |   | BOOKKEEPER  |   | DIARY                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13d. INSIDE CITY LIMITS?  |   |   |                                   |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN  |  |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |                                   |  |
| MARYLAND XXXXXX BALTIMORE   |  |  |  |   | 13e. STREET ADDRESS 21202   |   |   |                                   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |   |                                   |  |
| LOUIS KRAUS   |  |  |  |   | JO ANN E TITON  |   |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |                                   |  |
|   |  |  |  |   | 214018444   |   | Medical Records   |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4241 AORTIC STENOSIS   |  |  |  |   |   |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO OR AS A CONSEQUENCE OF (b) PERICARDITIS, chronic   |  |  |  |   |   |   |   |                                   | yes.   |
| DUE TO OR AS A CONSEQUENCE OF (c) undetermined  |  |  |  |   |   |   |   |                                   | recent                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |   |   |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                   |  |
| none  |  |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |                                   |  |
|   |  | P.M. 19  |  |   |   |   |   |                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |   |                                   |  |
|   |  |  |  |   |   |   |   |                                   |  |
| 22a. I certify that (1) this person attended the deceased from Feb 1974 to Nov 18 1978, that (1) I saw the deceased alive on Nov 18 1978, and that in (my) opinion death occurred on the date and hour and from the causes stated above (1) I was (did not) view the body after death |  |  |  |   |   |   |   |                                   |  |
| 22b. SIGNATURE  |  |  |  |   | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED                  |  |
| H.C. ALEXANDER, MD  |  |  |  |   |   |   |   | NOV 18 1978                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   | 22e. ADDRESS  |   |   |                                   |  |
| H.C. ALEXANDER, MD  |  |  |  |   | 301 ST. PAUL PLACE, Baltimore, Md   |   |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                         |   |                                   |  |
| Cremation   |  | 11/20/1978   |  | Green Mount   |   | Baltimore Maryland  |   |                                   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR                                   |   | 25b. REGISTRAR'S SIGNATURE        |  |
| Walter Brooks Bradley Inc. Balto., Md.  |  |  |  |   |   | NOV 21 1978   |   | History/Hubert                    |  |



1. The first part of the report deals with the general conditions of the country during the year. It is found that the weather was generally favorable, and the crops were well advanced. The stock raising industry was also doing well, and the people were generally satisfied with the progress of the year.

2. The second part of the report deals with the various industries of the country. It is found that the manufacturing industry was doing well, and the people were generally satisfied with the progress of the year. The mining industry was also doing well, and the people were generally satisfied with the progress of the year.

3. The third part of the report deals with the various branches of the government. It is found that the executive branch was doing well, and the people were generally satisfied with the progress of the year. The legislative branch was also doing well, and the people were generally satisfied with the progress of the year.

4. The fourth part of the report deals with the various branches of the government. It is found that the executive branch was doing well, and the people were generally satisfied with the progress of the year. The legislative branch was also doing well, and the people were generally satisfied with the progress of the year.

5. The fifth part of the report deals with the various branches of the government. It is found that the executive branch was doing well, and the people were generally satisfied with the progress of the year. The legislative branch was also doing well, and the people were generally satisfied with the progress of the year.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 4 1 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| Theodore Harris, SR.  |  | 11/28/79   |  | 9:45 P.M.  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)  | 7. IF UNDER 1 YEAR                                       |  |
| Male  | Negro  | 2 22 1907  | 72   | MONTHS DAYS HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |
| Maryland  | U. S. A.   |  | Baltimore City MD.   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |
| Baltimore   | Provident Hospital   |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?                                 | 13e. STREET ADDRESS  |
| Maryland  |  | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 3827 Roland View Avenue                                  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| Theodore Harris   |  | Mary E. Selden   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS  |  |  |
| No  |  | 219-22-7367  | John E. Harris 3827 Roland View Road   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) Cerebrovascular accident  |  |  |  |  |  |
| 4321 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |  |
| b) Possible cerebral bleed  |  |  |  |  |  |
| c) Possible subdural hematoma   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |
|   |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-27, 1979, to 11-28, 1979, that (I) (we) last saw the deceased alive on 11-28, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   | 22c. DATE SIGNED   |  |  |
| Patricia Jenkins  |  | MD   | 11-28-79   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |
| PATRICIA JENKINS, MD  |  | 2600 PROVIDENT HOSPITAL  |  | Baltimore 21216  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION  |  |  |
| Burial  | 12/3/1979  | Arbutus Mem. Park  | Arbutus Maryland   |  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                               |  |
| Wm. C. March F/H 1101 East North Avenue   |  | NOV 30 1979  |  | [Signature]  |  |



NOV 10 1972

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |   |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
|--|---------|---|--|---|--|---|--|--------------------------------------|--|--------------------------|-------|---|------|--|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH              |  | ESTIMATED                | MONTH | DAY   | YEAR | 2b. HOUR                                     |          |
| Willie Harris  |         |   |  |   |  |   |  | 11                                   |  |                          | 8     | 19  | 79   | M  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                     |  | 2c. DATE PRONOUNCED DEAD |       | MONTH   | DAY  | YEAR   | 2d. HOUR |
| Male   | Black   | 3 3 48  |  | 31 YRS.   |  |   |  |                                      |  | 11                       |       | 8   | 19   | 79   | 8:21P    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                          |       |   |      |  |          |
| N.C.   |         | USA   |  | WIDOWED   |  | DIVORCED  |  | Baltimore City, MD.                  |  |                          |       |   |      |  |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |                          |       |   |      |  |          |
| Baltimore City   |         | Johns Hopkins Hospital                                      |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |                          |       |   |      |  |          |
| Md.  |         |   |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 7670 Letrobe St.                     |  |                          |       |   |      |  |          |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                    |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS                              |  |                          |       |   |      |  |          |
| Unkn   |         | Gladys Harris   |  | 242-72-9054   |  | Celeste Harris Sapp   |  | 511 Georgetown Rd.                   |  |                          |       |   |      |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS   |  |                                      |  |                          |       |   |      |  |          |
| Yes  |         | Vietnam   |  | 242-72-9054   |  | Celeste Harris Sapp   |  | 511 Georgetown Rd.                   |  |                          |       |   |      |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |  |   |  |   |  |                                      |  |                          |       |   |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART I DEATH WAS CAUSED BY:  |         |   |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| IMMEDIATE CAUSE (a) <u>Asphyxia secondary to removal of tracheostomy tube</u>  |         |   |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| (b) _____  |         |   |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| (c) _____  |         |   |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |   |  |                                      |  |                          |       | 20. AUTOPSY?  |      |  |          |
|  |         |   |  |   |  |   |  |                                      |  |                          |       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |      |  |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                                      |  |                          |       |   |      |  |          |
|  |         | ? P.M. 11 8 19 79   |  | removed tracheostomy tube   |  |   |  |                                      |  |                          |       |   |      |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY                               |  | STATE                    |       |   |      |  |          |
|  |         | home  |  | 1710 Barclay St.  |  | Balto.  |  |                                      |  | MD                       |       |   |      |  |          |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |         |   |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |  | DATE SIGNED   |  |   |  |                                      |  |                          |       |   |      |  |          |
| <i>Thomas D. Smith</i>   |         | Deputy Chief  |  | 11/9/79   |  |   |  |                                      |  |                          |       |   |      |  |          |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| Thomas D. Smith, M.D.  |         | 111 Penn St. Balto., MD.                                    |  |   |  |   |  |                                      |  |                          |       |   |      |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | COUNTY                               |  | STATE                    |       |   |      |  |          |
| Burial   |         | 11/13/79  |  | George town Mem. Pk.  |  | Georgetown, N.C.  |  |                                      |  |                          |       |   |      |  |          |
| 24. FUNERAL DIRECTOR NAME  |         | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                      |  |                          |       |   |      |  |          |
| Wm C March F/H   |         | 1101 E. North Ave.  |  | Nov 13 1979   |  | <i>Robert H. Hardy</i>  |  |                                      |  |                          |       |   |      |  |          |

MEDICAL CERTIFICATION

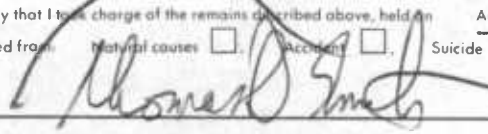
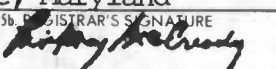
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

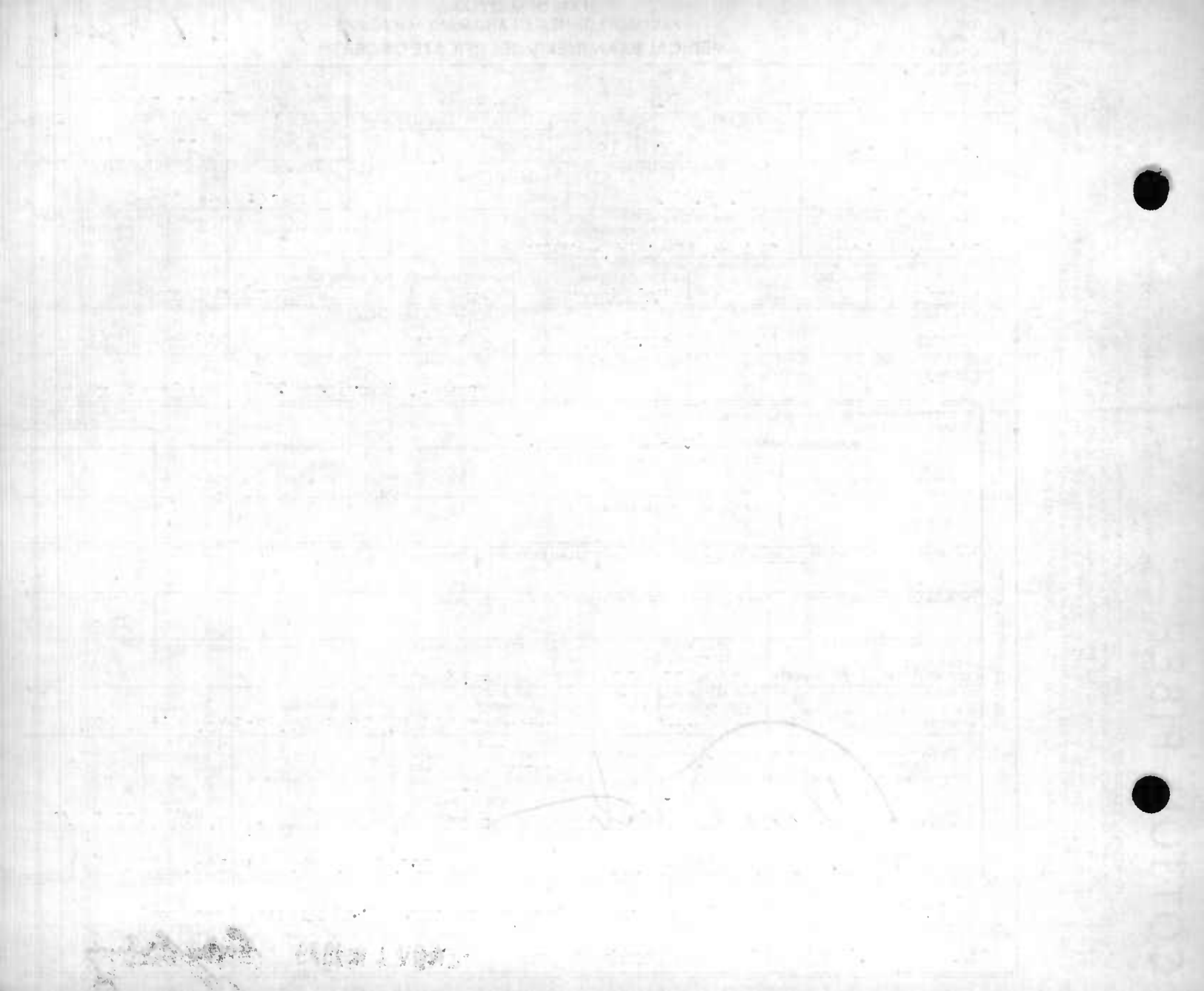
BP  
DHMH-17  
(VR A15 ME (5))  
30M 7/73



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |   |   |                  |   |  |   |  | REG. NO. 27421   |  |
|--|-------------------------|---|---|---|------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jonathan D. Harrison</b>  |                         |   |   |   |                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 15 1979</b>           |  | 7b. HOUR <b>M</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 24 60</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>19 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br><b>11 16 1979</b>   |  | 7d. HOUR <b>M</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>224 E. 22nd St. - rear</b> |   |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS<br><b>2329 Barclay Street</b>                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James T. Harrison</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Alice Wilson</b>   |                  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><b>Mary A. Harrison 2329 Barclay Street</b>  |                  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                         |   |   |   |                  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |   |   |   |                  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |                  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR <del>XXX</del> MONTH DAY YEAR<br><b>? P.M. 11 15 1979</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>subject shot</b>  |                  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>yard</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>rear of 224 E. 22nd St. Balto. City, MD.</b>  |                  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held in death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>                     |                         |   |   |   |                  |   |  |   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE<br>  |                         | TITLE (SPECIFY)<br><b>Deputy Chief</b>  |   |   |                  |   |  | DATE SIGNED<br><b>11/17/79</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |                         | ADDRESS<br><b>111 Penn St. Balto., MD.</b>  |   |   |                  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>11/21/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Calvary Cemetery</b>   |                  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 East North Avenue</b>   |                         |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1979</b>   |                  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |  |  |











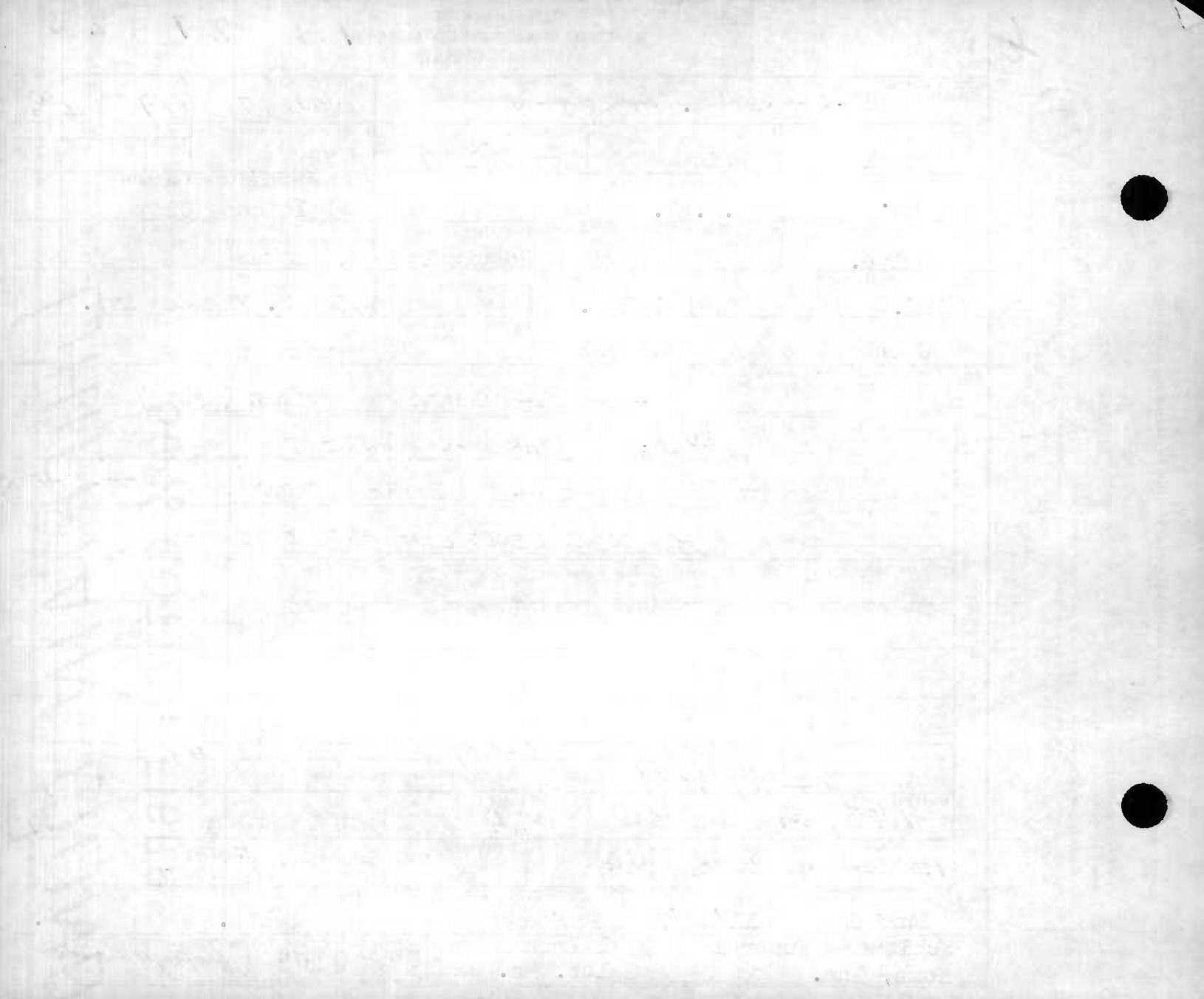
1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |  |   |  |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET B. HARTMAN</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Nov. 17, 1979</b>               |   |  | 2b. HOUR<br><b>4:00 P.M.</b>   |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov 25 1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |   |  |   | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George McNeill</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-34-5961</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>D Genevieve Hartman (dghtr) address same</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause (see instructions on back of form)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE <b>CARDIAC ARREST</b><br><b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHERO SCLEROTIC HEART DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>HALF HOUR</b> |  |   |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/04/79</b> 19 to <b>11/17/79</b> 19, that (I) (we) lost saw the deceased alive on <b>11/17/79</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Halesh M. Patel</b>   |  |   | DEGREE<br><b>M.D.</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>11/17/79</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HALESH M. PATEL, M.D.</b>  |  |   | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSPITAL<br/>BALTIMORE, MD 21239</b> |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>11/28/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Schumnek Funeral Home, Inc.</b>   |  |   | ADDRESS<br><b>3331 Brehms Lane<br/>Balto. Md. 21213</b>                |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey H. Brady</b>           |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |   |  |  |                        |   |  |  |  |  |  |
|--|--|--|---|--|---|--|--|------------------------|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |   |  | 7 9 2 7 4 2 4   |  |  |                        |   |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  |  |   |  | 2a DATE OF DEATH  |  |  |                        |   |  |  |  |  |  |
| LEROY HARVEY   |  |  |   |  | 11 30 '79 3:45 PM   |  |  |                        |   |  |  |  |  |  |
| 3 SEX  |  | 4 RACE   |   | 5 DATE OF BIRTH  |   | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 IF UNDER 1 YEAR      |   |  |  |  |  |  |
| Male   |  | Negro  |   | 10 4 1904  |   | 75 YRS   |  | MONTHS DAYS HOURS MIN. |   |  |  |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |                        |   |  |  |  |  |  |
| Virginia   |  | U. S. A.   |   |  |   | Baltimore City MD.   |  |                        |   |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |   |  |  |                        |   |  |  |  |  |  |
| Baltimore  |  | N. CHARLES ST. GENERAL HOSPITAL  |   |  |   |  |  |                        |   |  |  |  |  |  |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY   |   |  |   |  |  |                        |   |  |  |  |  |  |
|  |  |  |   |  |   |  |  |                        |   |  |  |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  | 13d INSIDE CITY LIMITS?   |  |  |                        |   | 13e STREET ADDRESS                           |  |  |  |  |
| Maryland   |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                        |   | 1826 North Castle Street                     |  |  |  |  |
| 14 FATHER'S NAME   |  |  |   |  | 15 MOTHER'S MAIDEN NAME   |  |  |                        |   |  |  |  |  |  |
| Collins W. Harvey  |  |  |   |  | Kate Gee  |  |  |                        |   |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |   |  | 16b SOCIAL SECURITY NO.   |  |  |                        |   | 17 INFORMANT ADDRESS                         |  |  |  |  |
|  |  |  |   |  | 213-07-1097   |  |  |                        |   | Ernestine Boone 2623 Lewllen Avenue          |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |   |  |   |  |  |                        |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |
| IMMEDIATE CAUSE (a) Advanced Carcinoma prostate  |  |  |   |  |   |  |  |                        |   |  |  |  |  |  |
| 185- DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |   |  |  |                        |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |   |  |   |  |  |                        |   | with Multiple Metastasis                     |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |   |  |  |                        |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |  |  |                        |   |  |  |  |  |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                     |  |   | 20a AUTOPSY?   |  |                        | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |
|  |  |  |   |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |                        | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |                        |   |  |  |  |  |  |
|  |  |  |   |  |   |  |  |                        |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |                        |   |  |  |  |  |  |
|  |  |  |   |  |   |  |  |                        |   |  |  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 11/11/79 to 11/30/79, that (we) last saw the deceased alive on 11/30/79, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |  |                        |   |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |   |  |   | DEGREE   |  |                        | 22c. DATE SIGNED  |  |  |  |  |  |
| Gopal Guruswamy  |  |  |   |  |   | MD   |  |                        | 11/30/79  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  |   | 22e. ADDRESS   |  |                        |   |  |  |  |  |  |
| GOPAL GURUSWAMY  |  |  |   |  |   | NORTH CHARLES HOSPITAL   |  |                        |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |                        | 23d. LOCATION CITY OR TOWN COUNTY STATE                       |  |  |  |  |  |
| Burial   |  |  | 12/4/1979   |  |   | Mt. Calvary Cemetery   |  |                        | Baltimore, Maryland   |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME   |  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR  |  |                        | 25b. REGISTRAR'S SIGNATURE                                    |  |  |  |  |  |
| Wm. C. March F/H 1101 East North Avenue  |  |  |   |  |   | DEC 3 1979   |  |                        | [Signature]   |  |  |  |  |  |

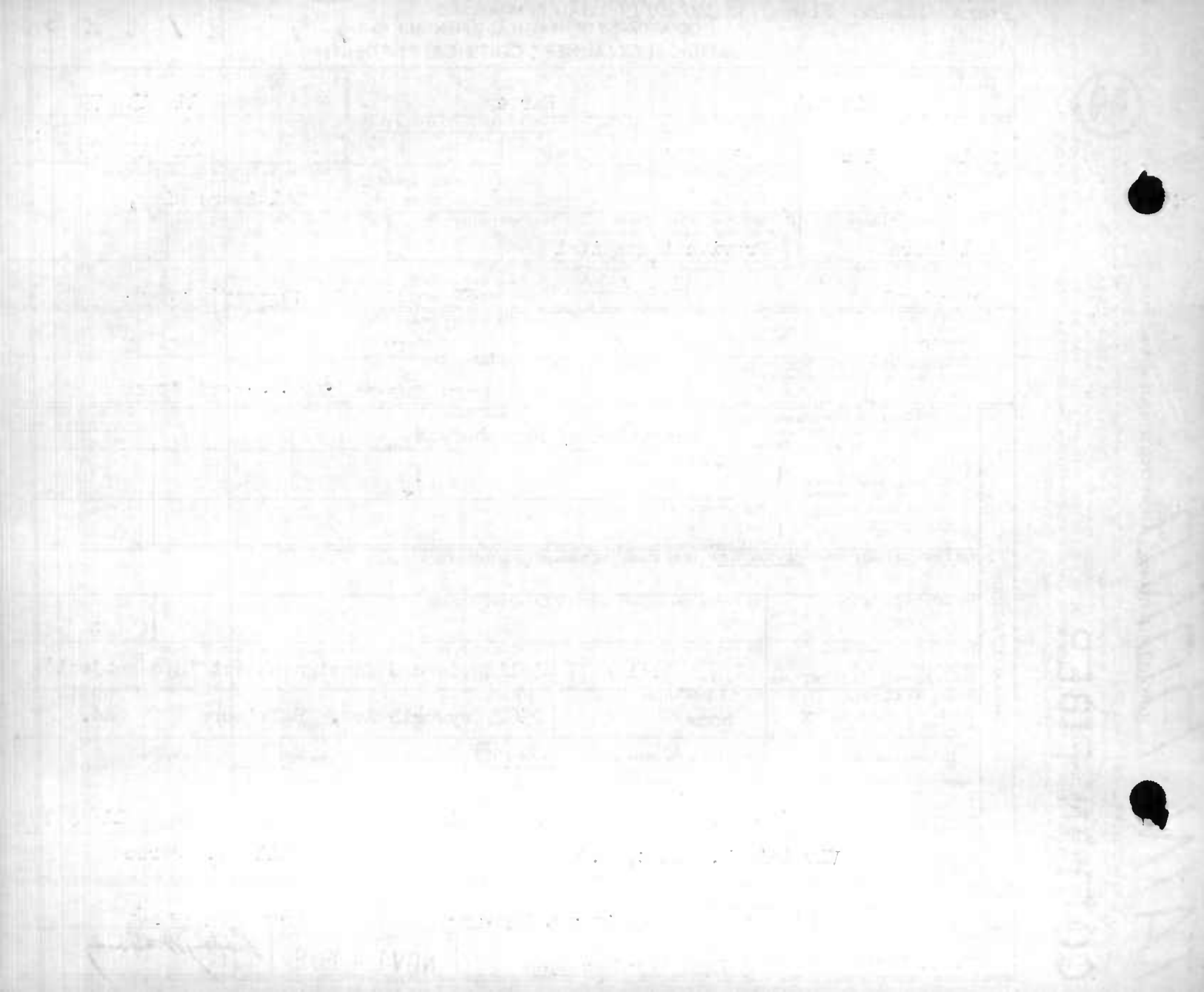


Items #18a-22a Film G538 12/20/79 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |   |  |   |   |  |   |  |
|--|-------------------------|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Michael Harvey</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 13 1979</b> |   |   | 2b. HOUR<br>M<br><b>6:10 A.M.</b>  |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 10 1979</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>2</b>  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN<br><b>2</b>   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 13 1979</b> |  | 2d. HOUR<br>M<br><b>6:10 A.M.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>       |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>2502 Keyworth Avenue</b>                       |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James A. Watson</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Bailey</b>  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |                         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Mary Harvey 2502 Keyworth Avenue</b>  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9289 IMMEDIATE CAUSE (a): Laceration of hypopharynx</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/13/79</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Sibling forced foreign object into subject's mouth</b>                  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2502 Keyworth Ave. Baltimore Md.</b>  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>   |  | MEDICAL EXAMINER  |   | DATE SIGNED<br><b>11/13/79</b>   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street</b>   |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>11/15/1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 East North Avenue</b>   |                         |   |  | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1979</b>                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b> |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | 7 9 2 7 4 2 6       |     |            |          |
|--|--|---|--|---|--|---|--|---|--|---------------------|-----|------------|----------|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |   |  |   |  |                     |     |            |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH               | DAY | YEAR       | 2b. HOUR |
| JOHN   |  | a.  |  | HASKETT   |  |   |  | 11  |  | 16                  | 79  | 6:00A      |          |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS     |     |            |          |
| MALE   |  | BLACK   |  | MONTH 2 DAY 19 YEAR 1893  |  | 86 YRS.   |  | MONTHS  |  | OAYS                |     | HOURS MIN. |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                     |     |            |          |
| SURRY CO. VA.  |  | U.S.A.  |  |   |  | BALTIMORE CITY  |  |   |  |                     |     | MD         |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                     |     |            |          |
| BALTIMORE  |  | VA MEDICAL CENTER BALTO.MD.   |  |   |  |   |  |   |  |                     |     |            |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |     |            |          |
| MARYLAND   |  |   |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  | 1129 BRENTWOOD AVE  |     |            |          |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |   |  |                     |     |            |          |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST   |  |   |  |   |  |   |  |                     |     |            |          |
| John A. Haskett  |  | Lou Emma  |  |   |  |   |  |   |  |                     |     |            |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                     |     |            |          |
| YES  |  | WW I  |  | 215-07-5572   |  | K/MA HASKETT  |  | 1129 BRENTWOOD AVE  |  |                     |     |            |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  | PART I. DEATH WAS CAUSED BY   |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                       |  |                     |     |            |          |
| 4149   |  | CARDIAC   |  | ARREST  |  |   |  | MINUTES   |  |                     |     |            |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b)   |  | CORONARY ARTERY DISEASE   |  |   |  | 1 YR  |  |                     |     |            |          |
|  |  | (c)   |  | ATHEROSCLEROSIS   |  |   |  | 5 YRS   |  |                     |     |            |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                       |  | BILATERAL LEG AMPUTATIONS   |  |   |  |   |  |   |  |                     |     |            |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |   |  |                     |     |            |          |
| 8-31-79  |  | ASCUD/CARCINOMA @ FOOT  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |   |  |                     |     |            |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |                     |     |            |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                     |     |            |          |
| 22a. I certify that (this hospital) attended the deceased from   |  | APRIL 27, 1979  |  | to  |  | NOV. 16, 1979   |  | that (we) last saw the deceased above (we) (did) (did not) view the body after death. |  |                     |     |            |          |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |   |  |                     |     |            |          |
| Christine L. Compton   |  | MD  |  |   |  | 11/16/79  |  |   |  |                     |     |            |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |   |  |   |  |                     |     |            |          |
| CHRISTINE L. COMPTON   |  | 3900 LOCH RAVEN BLVD. BALTO.MD. 21218   |  |   |  |   |  |   |  |                     |     |            |          |
| 23a. BURIAL, CREMATION, REMOVAL (EFFECT)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE                        |  |   |  |                     |     |            |          |
| Burial   |  | 11/18/79  |  | Cedar Hill  |  | Baltimore MD 21225  |  |   |  |                     |     |            |          |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |                     |     |            |          |
| Mansoor Ali 638 9th St. Baltimore MD   |  | NOV 19 1979   |  | Rafiqul Kabir   |  |   |  |   |  |                     |     |            |          |







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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rudolph D. Hatchett</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>9</b> YEAR <b>79</b>       |   |  | 2b. HOUR<br><b>10:00</b> <sup>A</sup> <sub>M</sub>                                    |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>27</b> YEAR <b>1933</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS                                      |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                        |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   | 13e. STREET ADDRESS<br><b>1809 East Federal Street</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Artway</b> MIDDLE <b>Hatchett</b> LAST <b>Hatchett</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Pauline</b> MIDDLE <b>Steinback</b> LAST <b>Steinback</b>  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Catherine Hatchett</b> ADDRESS<br><b>1809 East Federal Street</b> |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5679 cardiac arrest</b><br>IMMEDIATE CAUSE (a) <b>shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>peritonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes, chronic renal failure.</b>   |  |   |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> 19 <b>79</b> , to <b>11/9</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/9</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Thomi Paula Cutler M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |  |   |  | 22c. DATE SIGNED<br><b>11/9/79</b>  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NAOMI PAULA CUTLER</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>Baltimore City Hospital</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |   | 23b. DATE<br><b>11/14/1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore Co., Maryland</b> COUNTY STATE |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H 1101 East North Avenue</b> ADDRESS  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1979</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 9 2 7 4 2 8  |  |  |   |
|--|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR <b>XXXX</b> <b>AX</b>   |  |   |  | REG. NO.   |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUIS A. HAUCK (Hauck)</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 30 79</b>   |  | 2b. HOUR<br><b>7:05 A.M.</b>   |   |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-3-1902</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS  |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>CHAFFEUR</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OIL Co.</b>  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>9 S. POTOMAC ST.</b>   |   |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>—</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  |  |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM HAUCK</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LIZETTE —</b>   |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b SOCIAL SECURITY NO<br><b>218-14-9461</b>  |  | 17 INFORMANT ADDRESS<br><b>Wm. L. Hauck, Sr. - 1804 Saunders Way</b>   |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b><br><b>586-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PNEUMONIA</b><br><b>RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RESPIRATORY FAILURE</b>            |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |   |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a I certify that (I) (this hospital) attended the deceased from <b>11/20/79</b> to <b>11/30/79</b> , that (I) (we) last saw the deceased alive on <b>11/20/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |   |
| 22b SIGNATURE<br><b>W. A. Impagliatelli</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c DATE SIGNED<br><b>11/30/79</b>   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALKER A. IMPAGLIATELLI</b>   |  |   |  | 22e ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 NORTH BROADWAY BALTIMORE, MD 21231</b>   |  |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b DATE<br><b>12-3-79</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE Cem.</b>   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>   |   |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Charles Miller 2334 Jefferson St.</b>  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>DEC 3 1979</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>Robert M. ...</b>  |   |



3

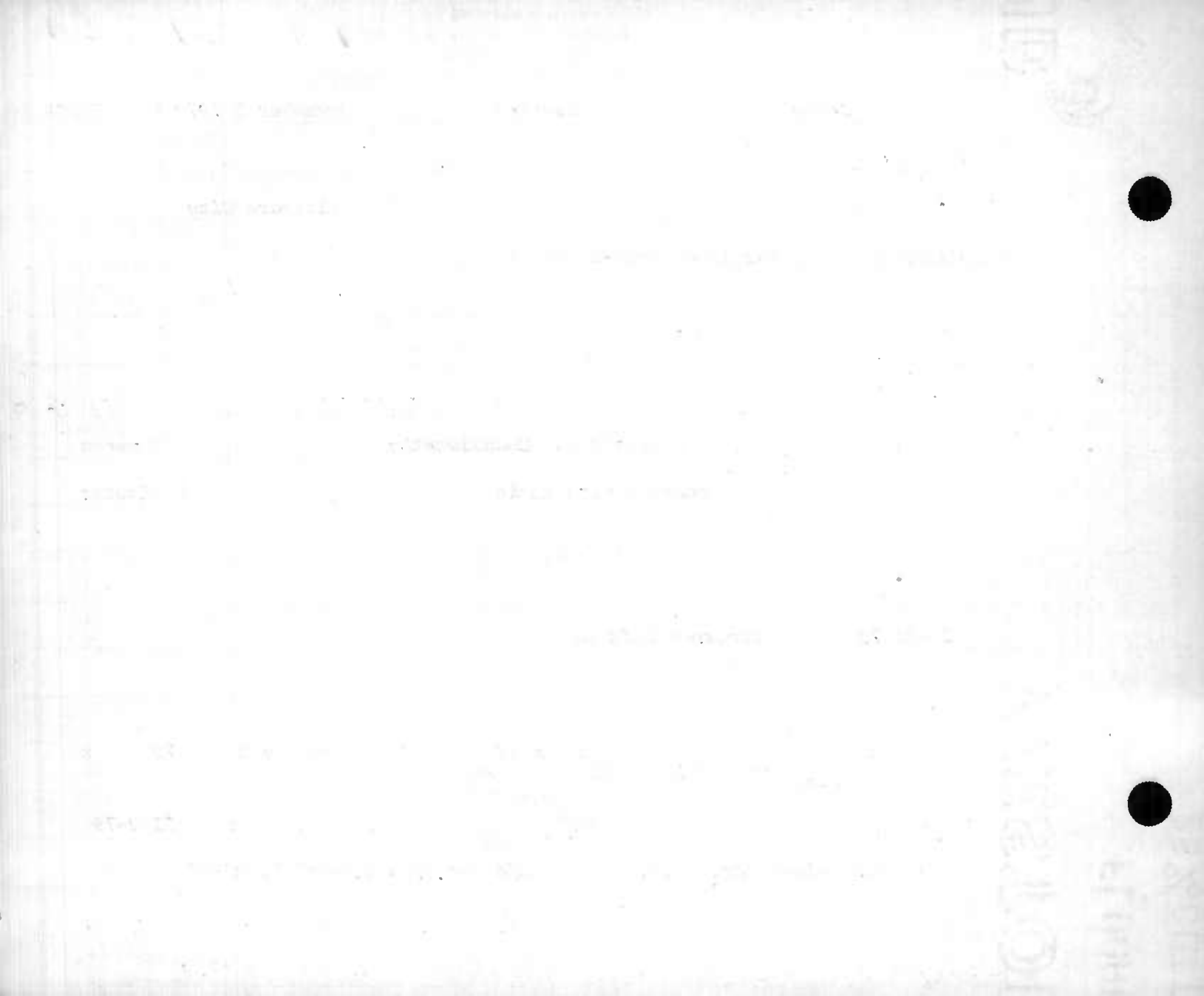
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  | 7 9 2 7 4 2 9  |  |   |  |          |
|---|--|--|---|--|--|--|---|--|----------|
| 1 - FOR STATE REGISTRAR   |  |  |   |  | REG. NO.   |  |   |  |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   | MIDDLE   | LAST   | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  | 2b. HOUR |
| James   |  |  |   |  | Hawkins  | November 2 1979  |   |  | 7:20A M  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR   |          |
| male  |  | Col  |   | 12-22-1901   |  | 77   |   | MONTHS DAYS HOURS MIN.   |          |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |          |
| Baltimore Md  |  | U.S.A.   |   |  |  | Baltimore City MD  |   |  |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |          |
| Baltimore   |  | Maryland General Hospital  |   |  |  | Retired  |   |  |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS  |          |
| Maryland  |  |  |   | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 1740 W. Lafayette Ave.   |          |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |  |   |  |          |
| Joseph  |  | Georgianna   |   |  |  |  |   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |  |   |  |          |
| NO  |  | 577-08-8160  |   | Carol Gilbert 5007 Gunther St Cap Hill Md  |  |  |   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |          |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis and Coagulopathy   |  |  |   |  |  |  |   | 2 weeks  |          |
| 0389  |  |  |   |  |  |  |   |  |          |
| DUE TO, OR AS A CONSEQUENCE OF Probable arrhythmia  |  |  |   |  |  |  |   | Minutes  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |   |  |  |  |   |  |          |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |  |   |  |          |
| (c)   |  |  |   |  |  |  |   |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |   |  |          |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |
| 10-28-79  |  |  | Gangrene Left Leg   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |          |
|   |  |  | P.M. 19   |  |  |  |   |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |          |
|   |  |  |   |  |  |  |   |  |          |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 22 19 79, to November 2 19 79, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 2 19 79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> not view the body after death. |  |  |   |  |  |  |   |  |          |
| 22b. SIGNATURE  |  |  |   |  | DEGREE   |  |   | 22c. DATE SIGNED   |          |
| George S. Malouf, Jr., MD   |  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 11-2-79  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  | 22e. ADDRESS   |  |   |  |          |
| George Malouf, Jr., M.D.  |  |  |   |  | c/o Maryland General Hospital  |  |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |          |
| Burial  |  |  | 11-7-79   |  | St Ignace Ch. Cem  |  | Oxon Hill Md.                           |  |          |
| 24. FUNERAL DIRECTOR NAME   |  |  |   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR           |  |          |
| Joseph L. Russ  |  |  |   |  | 2222 W. North Ave  |  | NOV 15 1979                             |  |          |
|   |  |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |          |
|   |  |  |   |  |  |  |   |  |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 4 3 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |  |  |  |   |  |  |
|---|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph A. Hawkins  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 16 79 |  |  | 2b. HOUR<br>9:50 AM   |  |  |
| 3 SEX<br>male   | 4 RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 10 92  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.     |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Machinist                           |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>md  |   |  |  | 13b COUNTY<br>Balto  |  | 13c CITY OR TOWN<br>Towson  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph A. Hawkins  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances M. Floyd   |  |  |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b SOCIAL SECURITY NO.<br>215-05-0067   |  | 17 INFORMANT<br>ADDRESS<br>Mrs. Ellen Hawkins Dulaney Valley Road  |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>1889<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Acute Renal Failure/Hypokalemia</u><br>(c) <u>Bladder Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Congestive Heart Failure &amp; Chronic Renal Failure</u>  |   |  |  |  |  |   |  |  |
| 19a DATE OF OPERATION<br>11/13/79   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Bladder Carcinoma   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12</u> , 19 <u>79</u> , to <u>Nov. 16</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.   |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br>Leah M. Vaughan MD  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/16/79  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Leah M. Vaughan  |   |  |  | 22e. ADDRESS<br>Mercy Hospital, Balto., Md.  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>11-19-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville, Baltimore, Md. |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc., Towson, Md. 21204  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Petry Helms                               |  |  |

MEDICAL CERTIFICATION

BP



CH 02

101-101-101





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

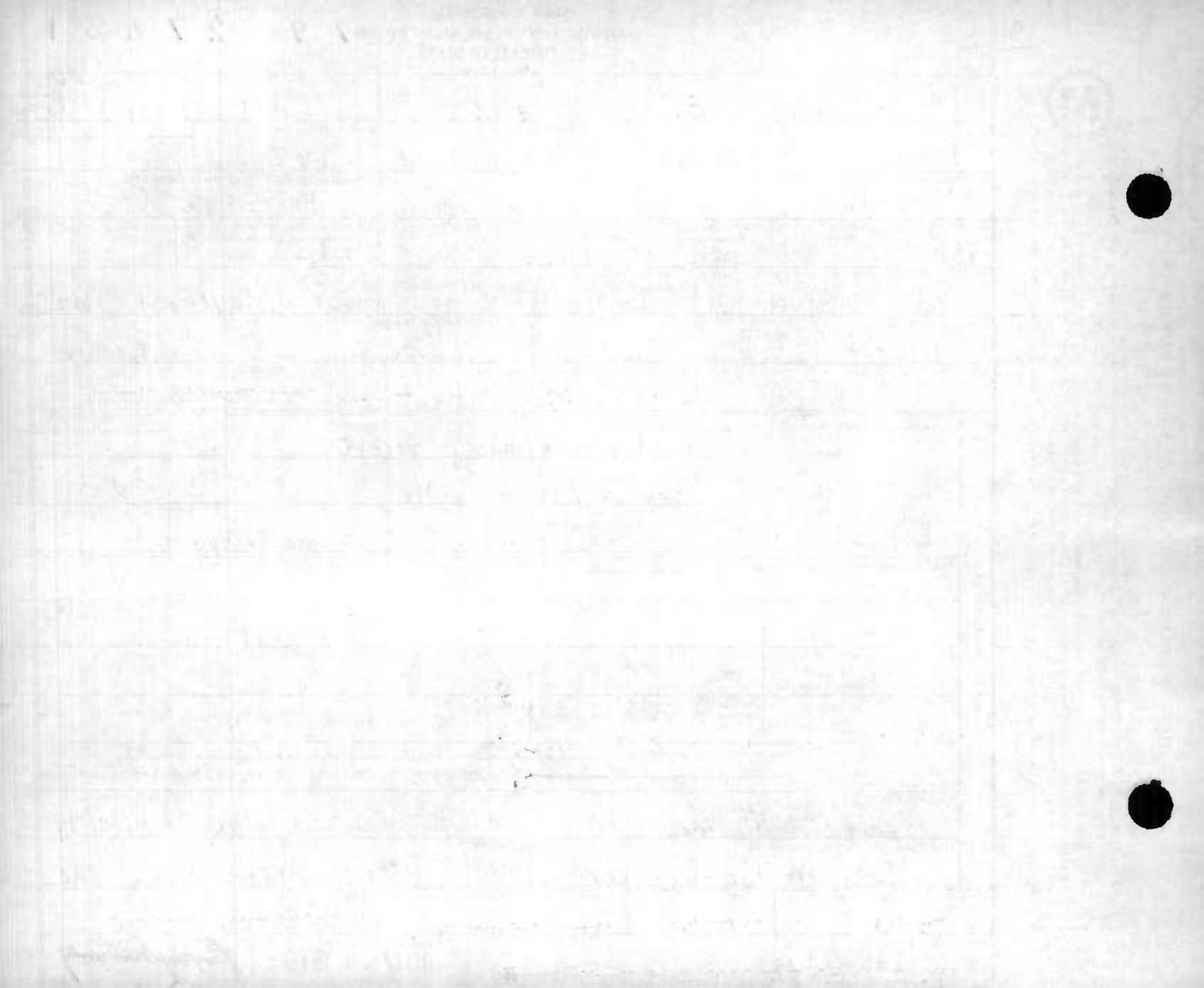
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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  | 7 9 2 7 4 3 1  |   |   |                                       |  |
|---|--|--|--|--|--|---|---|---------------------------------------|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  | REG. NO.   |   |   |                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED E. LAST HAWKINS  |  |  |  |  | 2a. DATE OF DEATH MONTH 11 DAY 19 YEAR 79                              |   |   | 2b. HOUR 1:45 PM                      |  |
| 3. SEX FEMALE   |  | 4. RACE BLACK  |  | 5. DATE OF BIRTH MONTH 06 DAY 14 YEAR 14   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.                     |   | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.     |   |                                       |  |
| 10. CITY OR TOWN OF DEATH BALTO.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MD. |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A      |   |   | 12b. KIND OF BUSINESS OR INDUSTRY     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE md 13c. COUNTY Balto City 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 13e. STREET ADDRESS 1609 W. Fayette St. 21223                          |   |   |                                       |  |
| 14. FATHER'S NAME FIRST Albert MIDDLE LAST Smith  |  | 15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE LAST Brown   |  |  |  |   |   |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. 219 07 8457   |  | 17. INFORMANT Patient 1609   |  | ADDRESS West Fayette Street                                 |   |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardio respiratory arrest<br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) sepsis / meningitis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) oat cell carcinoma, chemotherapy<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 dys |  |  |  |  |  |   |   |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |   |                                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |                                       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/16, 19 79, to 11/19, 19 79, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |   |                                       |  |
| 22b. SIGNATURE Joan M. Bathon MD  |  |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED 11/19/79                                   |   |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joan M. Bathon MD   |  |  |  | 22e. ADDRESS UNIV OF MD. HOSPITAL, BALTO, MD.  |  |   |   |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 11/23/79   |  | 23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland |   |                                       |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 East North Avenue   |  |  |  | DATE REC'D. BY REGISTRAR NOV 21 1979   |  | 25b. REGISTRAR'S SIGNATURE [Signature]                      |   |                                       |  |

1901



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO.   |  |                     |  |
|--|--|--|--|---|--|--|--|---|--|--|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST M. MIDDLE GILLETTE LAST HAYDEN  |  |  |  |   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 25, 1979   |  | 2b. HOUR<br>9:34 AM |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 2, 1892   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN   |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |   |  |  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Organist & Choir |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Director-Church  |  |  |  |                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE Maryland   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6019 Bellona Avenue   |  |                     |  |
| 14. FATHER'S NAME<br>FIRST George MIDDLE Gillett LAST Hayden   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Jennie MIDDLE Gibson LAST Reid  |  |  |  |   |  |  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>218-18-8575   |  | 17. INFORMANT<br>ADDRESS<br>Mr. G. Price Hayden 218 Blenheim Road                    |  |   |  |  |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chr. Pulmonary edema</u><br>3 max<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arteriosclerotic C.V. Disease</u><br>15 yrs |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |  |  |   |  |  |  |                     |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |  |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |  |  |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 1964</u> to <u>Nov 25, 1979</u> , that (I) (we) lost<br>saw the deceased alive on <u>Nov 23, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |  |  |                     |  |
| 22b. SIGNATURE<br><u>Frederick J. Vollmer, M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>11-26-79  |  |  |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Frederick J. Vollmer, M.D.  |  |  |  | 22e. ADDRESS<br>6100 York Road  |  |  |  |   |  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>11-27-1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Maryland  |  |  |  | ADDRESS<br>1050 York Road   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia Kelly</u>   |  |  |  |                     |  |

| NAME OF PLANT    | COUNTRY OF ORIGIN | CULTIVATED | SPECIES | COLLECTOR |
|------------------|-------------------|------------|---------|-----------|
| CITRUS AURANTIUM | INDIA             | YES        | C. A.   | J. H. R.  |
| CITRUS LIMON     | ITALY             | YES        | C. L.   | J. H. R.  |
| CITRUS SINENSIS  | CHINA             | YES        | C. S.   | J. H. R.  |
| CITRUS BERGAMOTI | ITALY             | YES        | C. B.   | J. H. R.  |
| CITRUS DULCIS    | ITALY             | YES        | C. D.   | J. H. R.  |
| CITRUS AURANTIUM | INDIA             | YES        | C. A.   | J. H. R.  |
| CITRUS LIMON     | ITALY             | YES        | C. L.   | J. H. R.  |
| CITRUS SINENSIS  | CHINA             | YES        | C. S.   | J. H. R.  |
| CITRUS BERGAMOTI | ITALY             | YES        | C. B.   | J. H. R.  |
| CITRUS DULCIS    | ITALY             | YES        | C. D.   | J. H. R.  |
| CITRUS AURANTIUM | INDIA             | YES        | C. A.   | J. H. R.  |
| CITRUS LIMON     | ITALY             | YES        | C. L.   | J. H. R.  |
| CITRUS SINENSIS  | CHINA             | YES        | C. S.   | J. H. R.  |
| CITRUS BERGAMOTI | ITALY             | YES        | C. B.   | J. H. R.  |
| CITRUS DULCIS    | ITALY             | YES        | C. D.   | J. H. R.  |
| CITRUS AURANTIUM | INDIA             | YES        | C. A.   | J. H. R.  |
| CITRUS LIMON     | ITALY             | YES        | C. L.   | J. H. R.  |

RECEIVED MAY 4 1904

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 27433

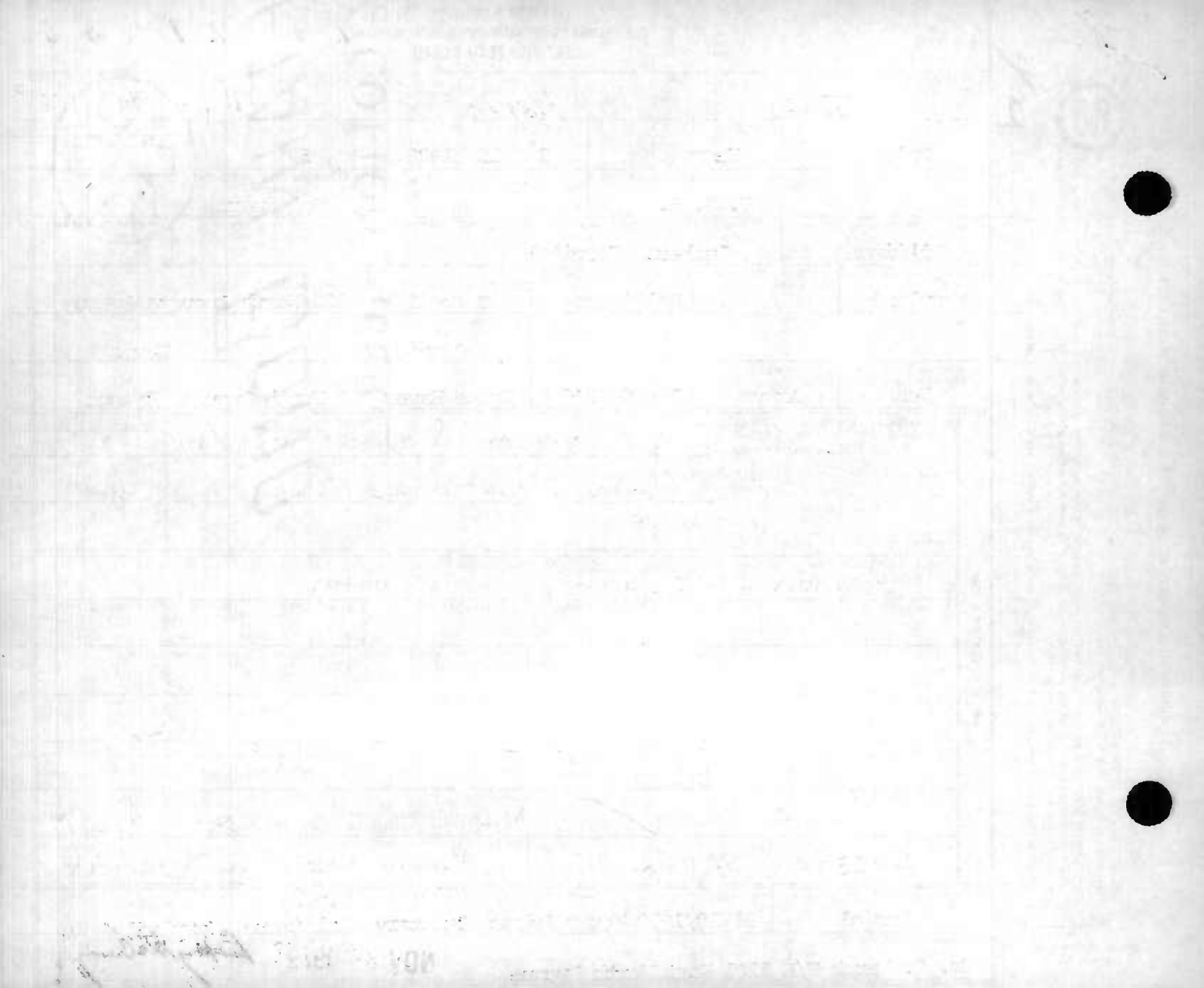
1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |   |  |   |  |
|--|--|---|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>James</i>   |  |   | 2a. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>6</i> YEAR <i>79</i>                  |   |  | 2b. HOUR<br><i>1.00</i> P.M.  |   |  |   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>Negro</i>   |   | 5. DATE OF BIRTH<br>MONTH <i>3</i> DAY <i>15</i> YEAR <i>1920</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>59</i> YRS.                           |   | 7. IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN. <i></i>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i></i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore</i> MD.                |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hospital</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i></i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i></i>   |   |  |
| 13a. STATE<br><i>Maryland</i>  |  |   |   |   | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <i></i> MIDDLE <i></i> LAST <i></i>   |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Connie</i> MIDDLE <i></i> LAST <i>Hayes</i>   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>   |  |   | 16b. SOCIAL SECURITY NO.<br><i>238-26-6546</i>                                    |   | 17. INFORMANT<br>ADDRESS<br><i>Irene Hayes 822 North Augusta Avenue</i>  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction with block</i><br><i>410-</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i></i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i><br><i>years</i> |  |   |   |   |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><i>Congestive heart failure, Diabetes mellitus.</i>  |  |   |   |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><i></i>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i></i>                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>                 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i></i>  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i></i> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i></i>   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/6</i> , 19 <i>79</i> , to <i>11/6</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/6</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><i>Sujeta Sapiri</i>   |  |   |   |   | DEGREE<br><i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><i>11/6/79</i>                                      |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SUJETA SAPSIRI, M.D.</i>   |  |   |   |   | 22e. ADDRESS<br><i>Lutheran Hospital of Maryland.</i>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>11/10/1979</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mount Auburn Cemetery</i>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm. C. March F/H 1101 East North Avenue</i>   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 8 1979</i>   |   |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

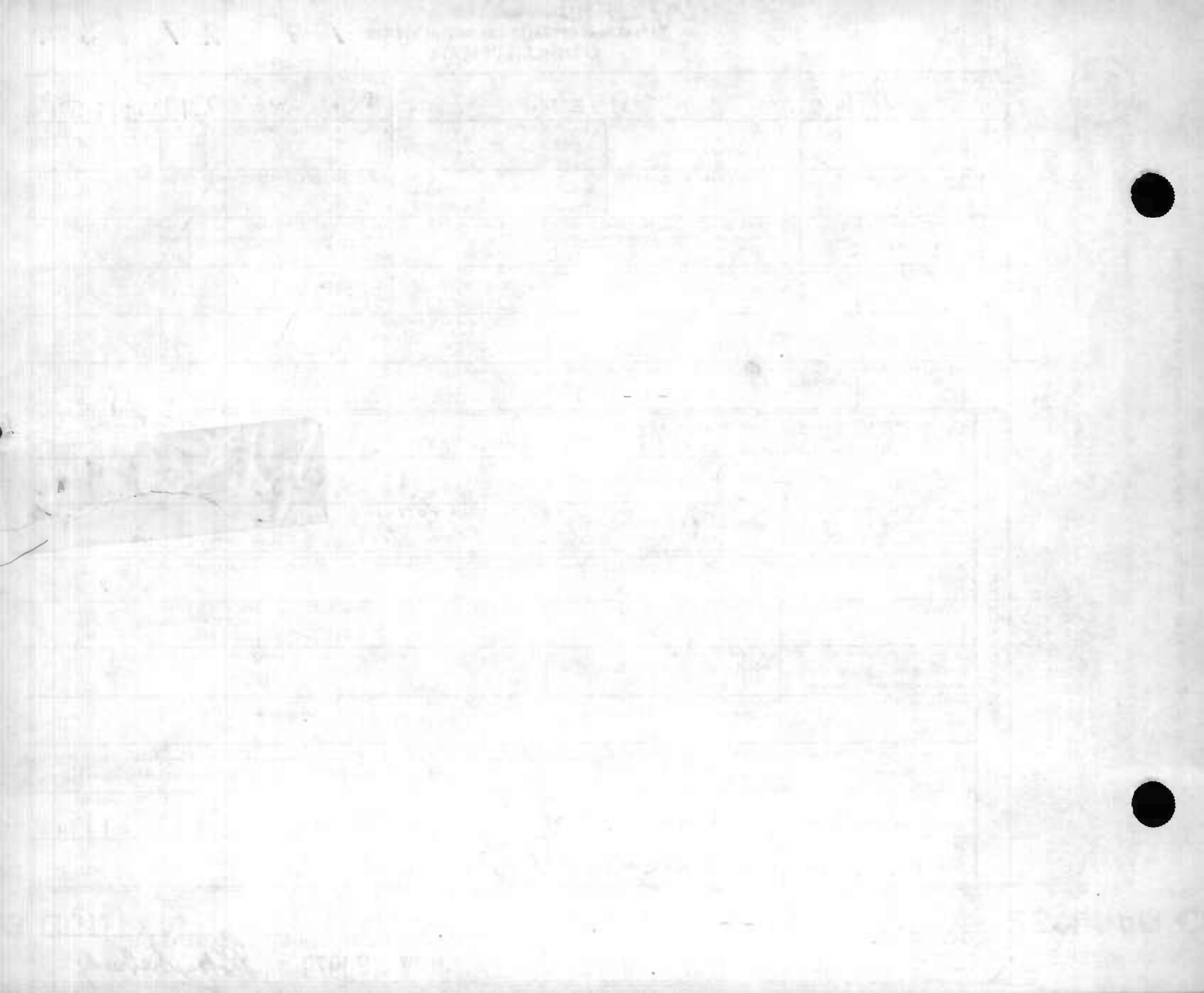
7 9 2 7 4 3 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William HAYES</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>27</b> YEAR <b>1979</b>   |  | 2b. HOUR<br><b>9:50 P.M.</b>  |   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>9</b> YEAR <b>23</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.                    | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALT. CITY</b> MD. |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DISABLED</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>707 CUMBERLAND STREET</b> |
| 14. FATHER'S NAME<br>FIRST <b>JOEL</b> MIDDLE <b>W.</b> LAST <b>HAYES</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>AGNES</b> MIDDLE <b></b> LAST <b>STEWART</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO<br><b>243-30-1941</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>EDNA ALLEN</b><br><b>WOODLAND AVENUE (SISTER)</b>                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOpulmonary arrest</b><br><b>496-</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>congestive heart failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF <b>respiratory failure</b><br>(c) <b>chronic obstructive lung disease, pneumonia</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M.</b> <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/27/1979</b> to <b>11/27/1979</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/27/1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Winston Hugh Williams MD</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/27/79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Winston Hugh Williams MD</b>   |  | 22e. ADDRESS<br><b>C/O Provident Hospital</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>12-3-79</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CENT</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>PHILLIPS FUNERAL HOME</b>   |  | ADDRESS<br><b>1721 N. MONROE STREET</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1979</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>L. H. H. H.</b>    |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |   |   |   |  |  |  |  |
|--|--|--|--|--|---|--|---|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 7 9 2 7 4 3 5<br>REG. NO.   |  |   |   |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Charlotte, Hayne   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 28 79  |  |   |   |   | 2b. HOUR<br>5:20pm<br>M  |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 16, 1890  |   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>88 89<br>YRS                              |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, Maryland City, Md.        |   |   |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Apt. 123 W29th St |  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>none                           |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>123 W29th St. Apt. 14J                               |   |   |  |  |  |  |
| 13a. STATE -   |  |  |  |  | 13b. COUNTY -   |  | 13c. CITY OR TOWN -   |   |   |  |  |  |  |
| 14 FATHER'S NAME<br>Hiram Rusk   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Eliza Leorina   |  |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213 14 3824 A   |  | 17 INFORMANT ADDRESS<br>Hiram Rice 1208 Chatham St. Balto. Md.              |   |   |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause defining for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic C. Vascular</u><br>4029 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 YRS. |  |  |  |  |   |  |   |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/16/79</u> , 19 <u>79</u> to <u>11/28</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Benjamin H. Hiltstein</u>   |  |  |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   | 22c. DATE SIGNED<br>11/29/79  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BENJAMIN HILTSTEIN  |  |  |  | 22e. ADDRESS<br>1218 HIGHLAND AVE BALTO. MD 21204  |   |  |   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>12/3/79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park                        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Co. Md.              |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home 6500 York Rd. Bal. Md.   |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1979                                    |   |   |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McBrady</u> |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

PHM - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 4 3 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Annie Mae Haynesworth   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 7 79 |   |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>F  |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 9 49  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>30<br>YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City<br>MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN EACH CITY, GIVE STREET ADDRESS)<br>507 Half Mile Ct. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Leim Haynesworth   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louise Thompson   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-50-4241   |  | 17. INFORMANT<br>ADDRESS<br>Louise Haynesworth 507 Half Mile Ct.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Rheumatic heart disease</u><br>3949<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 years |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Prosthetic mitral valve</u>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1978</u> to <u>Nov 7, 1979</u> , that (I) (we) last saw the deceased alive on <u>10/15</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>James H. Biddison, MD</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>11/8/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>J BIDDISON</u>   |  |  |  | 22e. ADDRESS<br><u>1900 E Northern Parkway</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/12/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H   |  |  |  | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1979  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

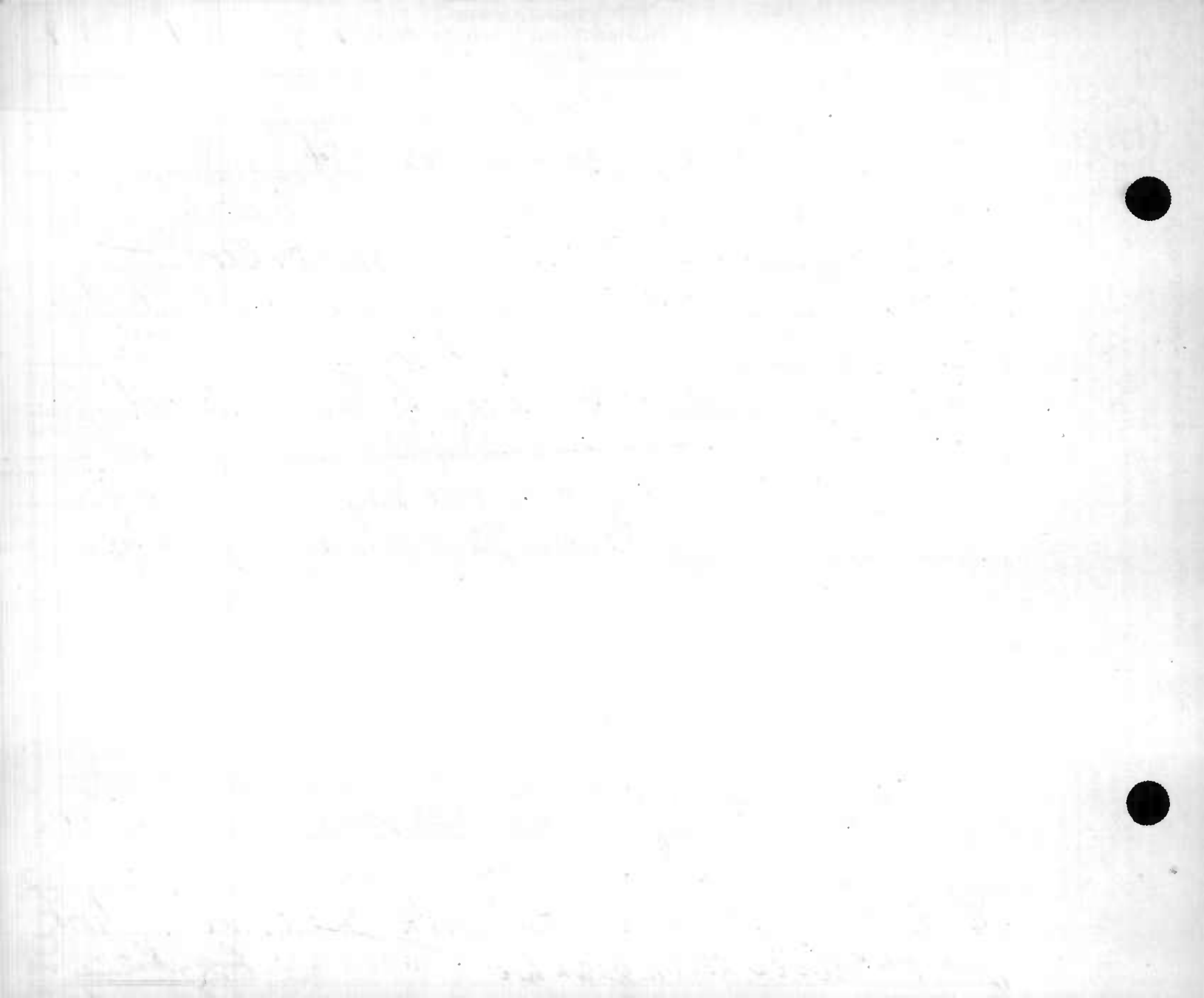
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   | 7 9 2 7 4 3 7 |   |  |
|--|--|--|---|---|---------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.  |   |               |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Catherine W. HAYNIE</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>11-23-79</i> |   | 2b. HOUR<br>M |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Col</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>Sept 30 1905</i>  |               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>BALTO. Md</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>2215 W. North Ave.</i>   |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>  |               | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Maryland</i>                               |  | 13b. COUNTY<br><i>BALTO.</i>   |   | 13c. CITY OR TOWN<br><i>BALTO.</i>  |               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>ESSAC White</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Hellie White</i>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>218-08-8590</i>   |  |
| 17. INFORMANT<br>ADDRESS<br><i>Mr. Paul Better 2326 Arunah Ave</i>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i><br>4-10-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Dependence Acute Disease</i><br>(c) <i>Coronary Artery Heart Disease</i> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>10 year -</i><br><i>10 year -</i>  |               | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |               | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |               | 22b. SIGNATURE<br><i>H. William Primakoff</i><br>DEGREE<br><i>M.D.</i><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/><br>22c. DATE SIGNED<br><i>11-27-79</i> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>H. William Primakoff</i>   |  | 22e. ADDRESS<br><i>3900 North Charles St.</i>  |   | 23a. BURIAL, CREMATION, REMOVAL<br>(BY)<br><i>Burial</i>  |               | 23b. DATE<br><i>11/29/79</i>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Greenwood Burial Pk.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore</i>   |   | 24. FUNERAL DIRECTOR<br><i>Joseph L. Rice</i><br>ADDRESS<br><i>2221 W. North Ave.</i>   |               | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 27 1979</i>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Anthony A. Brady</i>  |  | 25c. DATE REC'D. BY REGISTRAR<br><i>NOV 27 1979</i>  |   | 25d. REGISTRAR'S SIGNATURE<br><i>Anthony A. Brady</i>   |               | 25e. DATE REC'D. BY REGISTRAR<br><i>NOV 27 1979</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                        |   |   | 7 9 2 7 4 3 8  |  |  |  |
|---|------------------------|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |                        |   |   | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WINIFRED P. HEAD</b>  |                        |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 17, 1979</b> |  |  | 2b. HOUR<br><b>8:30p M</b>   |  |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 27 1892</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>86</b>   |  | # UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>England</b>   |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |                        |   |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Hines</b>   |                        |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kathleen Kelly</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                        | 16b. SOCIAL SECURITY NO<br><b>213-07-2330</b>   |   | 17 INFORMANT<br>ADDRESS<br><b>Charles H. Head - Balto. MD 21222</b>  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Intracerebral Bleed</b><br><b>431-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebrovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |                        |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>11/8/</b> 19 <b>79</b> , to <b>11/17/</b> 19 <b>79</b> , that <b>X</b> (we) lost saw the deceased alive on <b>11/17/</b> 19 <b>79</b> , and that in <b>MD</b> (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.   |                        |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>James Cockey, M.D.</b>   |                        |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br><b>11/17/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |                        |   |   | 22e. ADDRESS<br><b>c/o 827 Linden Ave. Balto. MD 21201</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                        | 23b. DATE<br><b>11/21/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b><br>ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>  |                        |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

002-0

NOVEMBER 17, 1978

HEAD

UNITED STATES

Baltimore City

Maryland General Hospital

Baltimore

Interneutroal Nlead  
Cerebrovascular Disease

70

11/17/78

70

11/17/78

11/17/78

11/17/78

11/17/78

11/17/78

410 617 Linden Ave. Balto. MD 21201

James Cooke, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 4 3 9

|   |   |   |   |
|---|---|---|---|
| 1. FOR STATE REGISTRAR  |   | REG. NO.  |   |
| 1 DECEASED NAME (TYPE OR PRINT) <b>MISSOURI V. HEATHERLY</b>  |   | 2a DATE OF DEATH MONTH DAY YEAR <b>November 19, 1979</b>  |   |
| 3 SEX <b>Female</b>   | 4 RACE <b>White</b>   | 5 DATE OF BIRTH MONTH DAY YEAR <b>June 16, 1917</b>   | 6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>   | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>ST. JOSEPH'S HOSPITAL 3805 Pascal Street 21226</b> | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>   | 13b COUNTY <b>---</b>   | 13c CITY OR TOWN <b>Baltimore</b>   | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>William Grindstaff</b>  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Sarah Jane Grindstaff</b>   |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>227 05 5819</b>   | 17 INFORMANT <b>Jeannette Knight</b> ADDRESS <b>3805 Pascal Street Baltimore, Md. 21226</b>   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b>   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cor Pulmonale</b>   |   |   |   |
| (c) <b>LT lung Carcinoma</b>  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>chronic obstructive Pulmonary Disease</b>   |   |   |   |
| 19a DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>6/20</b> 19 <b>77</b> to <b>11/20</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11-13</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |   |   |   |
| 22b. SIGNATURE <b>Joseph H. Miller MD</b>   | DEGREE <b>MD</b>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              | 22c. DATE SIGNED <b>11-21-79</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH H Miller MD</b>   | 22e ADDRESS <b>900 CATON AVE. BALTIMORE, MD. 21229</b>  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   | 23b. DATE <b>Nov. 24, 1979</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>  |
| 24. FUNERAL DIRECTOR NAME <b>McUllly Funeral Home of Brooklyn Balto., Md.</b>   | 24b. ADDRESS <b>237 East Patuxent Avenue</b>  |   | 25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1979</b>  |
| 25b. REGISTRAR'S SIGNATURE <b>Barbara A. Brady</b>  |   |   |   |



BALTIMORE CITY

X

ST. LOUIS  
MO. 63101

BALTIMORE

X

500 CATON AVE. BALTIMORE, MD. 21206

*Handwritten signature*

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 4 4 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

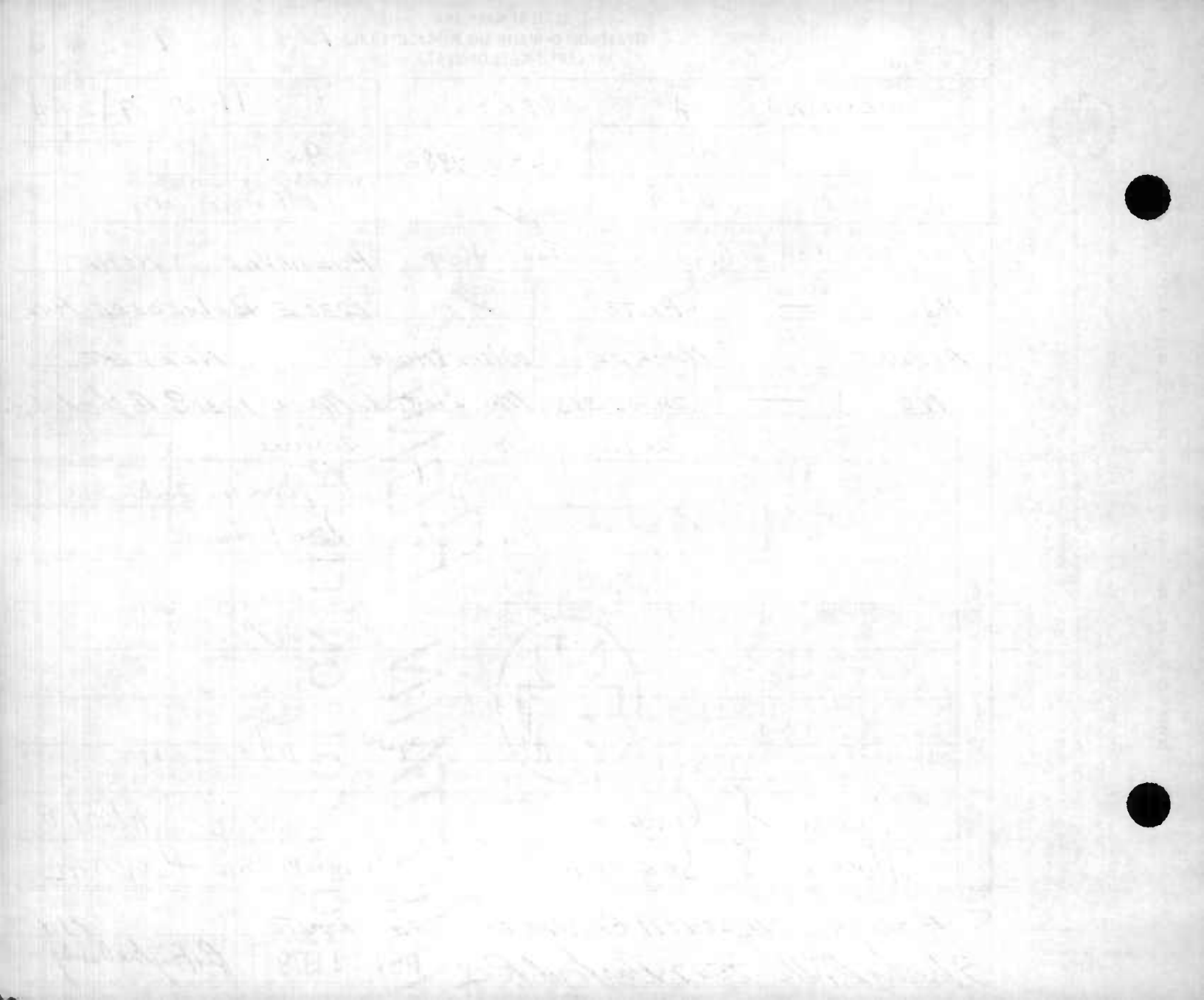
|  |                      |   |  |   |
|--|----------------------|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SUZANNA A HEBBEL</b>  |                      | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>27</b> YEAR <b>79</b>   |  | 2b. HOUR<br><b>2:40 A.M.</b>  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W.</b> | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>05</b> YEAR <b>1886</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b>  |                      | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |   |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hosp.</b>  |                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>—</b> 13c. CITY OR TOWN <b>BALTO.</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1230 E. BELVEDERE AVE.</b>  |                      |   |  |   |
| 14. FATHER'S NAME<br>FIRST <b>ALBERT</b> MIDDLE <b>—</b> LAST <b>NACKEL</b>  |                      | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>WILHELMINA</b> MIDDLE <b>—</b> LAST <b>NEETZKE</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |                      | 16b. SOCIAL SECURITY NO.<br><b>216-05-3136</b>  |  | 17. INFORMANT<br><b>Mrs. Gertrude Miller 1230 E. Belvedere Ave.</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary Failure.</b><br>496-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>COPD. Acute Respiratory Failure</b><br>(c) <b>Right lower lobe pneumonia.</b>             |                      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>None</b>  |                      |   |  |   |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/26</b> , 19 <b>79</b> , to <b>11/27</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/27/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                      |   |  |   |
| 22b. SIGNATURE<br><b>Husein S. Sonara</b>  |                      | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/27/79</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HUSEIN S. SONARA</b>   |                      | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSPITAL.</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |                      | 23b. DATE<br><b>11-30-1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |                      | 24. FUNERAL DIRECTOR<br>NAME <b>Harthy Miller</b> ADDRESS <b>7527 Harford Rd.</b>   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1979</b>  |                      | 25b. REGISTRAR'S SIGNATURE<br><b>Christy K. K...</b>  |  |   |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

27441  
005941FOR  
1 - STATE  
REGISTRAR

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL MOSES HECHT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/30/79</b> |   |  | 2b. HOUR<br><b>443A</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 28 1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Investments</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>  |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><b>11001 BARONET RD. Owings Mills (4211)</b>                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MOSES SAMUEL HECHT</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BLANCH HARTMAN</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b> <b>WWII-AIR FORCE 213-10-6194</b>   |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>XXXXXX XXXX XXXX</b>  |  | 17. INFORMANT <b>MRS. RUTH S. HECHT</b><br><b>11001 BARONET RD., OWINGS MILLS, MD 21117</b>                                  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory failure</b><br><b>1520</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>malignant melanoma duodenum</b>  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/1/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bleeding tumor duodenum</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>79</b> , to <b>11/30</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/30</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (and) did not view the body after death.            |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>DeGraw</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br><b>11/30/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. M. Gann</b>  |  | 22e. ADDRESS<br><b>Sinai Hosp. of Baltimore</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>DEC. 2, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>REISTERSTOWN BALTO. MD</b>            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 5 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barney Halvord</b>   |  |  |  |  |  |

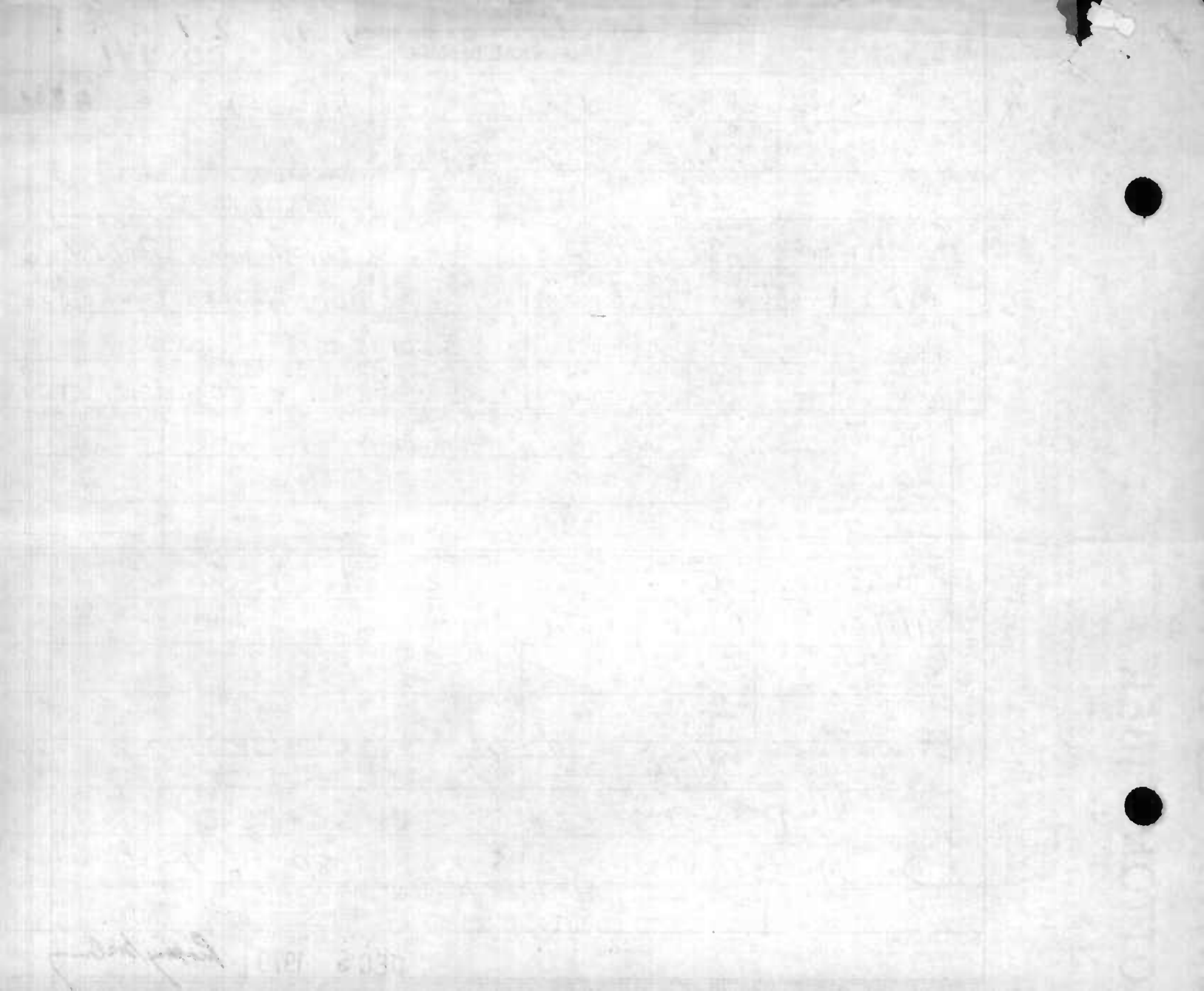
6010 REISTERSTOWN RD. BALTO. MD 21215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 2 7 4 4 2

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Henry F. Hedrick</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Nov. 23, 1979</b>                                       |   | 2b. HOUR<br><b>M</b>  |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 29, 1909</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |   |   |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5002 Arabia Ave.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner - Taxicab Co.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>5002 Arabia Ave.</b>  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hedrick</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW 11 217-03-8551</b>   |  | 17 INFORMANT ADDRESS<br><b>Mr. William Hedrick Same as #13e</b>                                 |   |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410- Probable myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> |  |  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |   |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. _____ 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-</b>      |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>-</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Dan H. McDougal MD.</b>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>11/24/79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>McDOUGAL</b>   |  | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSP, DEPT. MEDICINE</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Nov. 26, 1979</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>  |  | ADDRESS<br><b>Balto., Md.</b>  |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 26 1979</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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Nov. 23, 1959

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2002 Arabia Ave.

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Yes

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117-63-8231 Mr. William Edwin

WEDSTON

2002 Arabia Ave.

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Leonard J. Koch, Inc.

Baltimore, Md. NOV 20 1959

Students of - Baltimore

Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |  |   |  |   |  |
|---|--|---|--|--|--|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |   |  |  | 7 9 2 7 4 4 3  |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |   |  |  | REG. NO.   |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST<br>LUTHER SCOTT HEMCKY                               |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 30 79                                   |  |   | 2b. HOUR<br>5 P.M.   |   |  |
| 3. SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 5 23  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS   |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.                               |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>857 Woodward St. |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   | 13a. CITY OR TOWN<br>Md.   |  |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  | 13c. STREET ADDRESS<br>857 Woodward St.               |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                             |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>723-18-2727                                |  |  | 17 INFORMANT ADDRESS   |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u><br>4912<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Pulmonary Emphysema</u><br>(c) <u>Chronic Bronchitis</u>                              |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>2 years</u><br><u>5 years</u>                          |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Pulmonary Tuberculosis 1965</u>  |  |   |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a I certify that (I) (the hospital) attended the deceased from <u>11/30</u> , 19 <u>79</u> , to <u>11/30</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>John P. Urlock Jr</u> M.D.   |  |   |  |  | DEGREE<br><u>MD</u>  |  |   | 22c. DATE SIGNED<br><u>12/4/79</u>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JOHN P. URLOCK JR M.D.</u>  |  |   |  |  | 22e. ADDRESS<br><u>1227 Washington Blvd 21230</u>                              |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Removal</u>  |  |   | 23b. DATE<br><u>11/30/79</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE          |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>Anatomy Board</u>   |  |   |  |  | ADDRESS<br><u>Balto., Md.</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC 12 1979</u> |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey M. Brady</u> |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Roland Henderson Joseph Henderson                                      |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 14 79   |  | 2b. HOUR<br>9:45 P.M.   |
| 3. SEX<br>Male  | 4. RACE<br>CAUCASIAN  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 30 1922   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PAINTER                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>MAINTENANCE                 |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                       |   |   |   |  |   |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>CALVERT  | 13c. CITY OR TOWN<br>NORTH BEACH  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>9313 Bay Ave North Beach Md.              |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>STEPHEN   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIA ALICE CUMMINGS   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>WW II YES |   | 16b. SOCIAL SECURITY NO.<br>577-18-4718   |   | 17. INFORMANT<br>KATHRYN HENDERSON 9313 BAY AVENUE (NORTH BEACH) |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>                     |  | 24 MINUTES                                   |
| 496 -<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | (b) DUE TO, OR AS A CONSEQUENCE OF<br><u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> | 20 YEARS?                                    |
|   | (c) DUE TO, OR AS A CONSEQUENCE OF<br><u>ADVANCED PULMONARY TUBERCULOSIS</u>       | 2 YEARS?                                     |

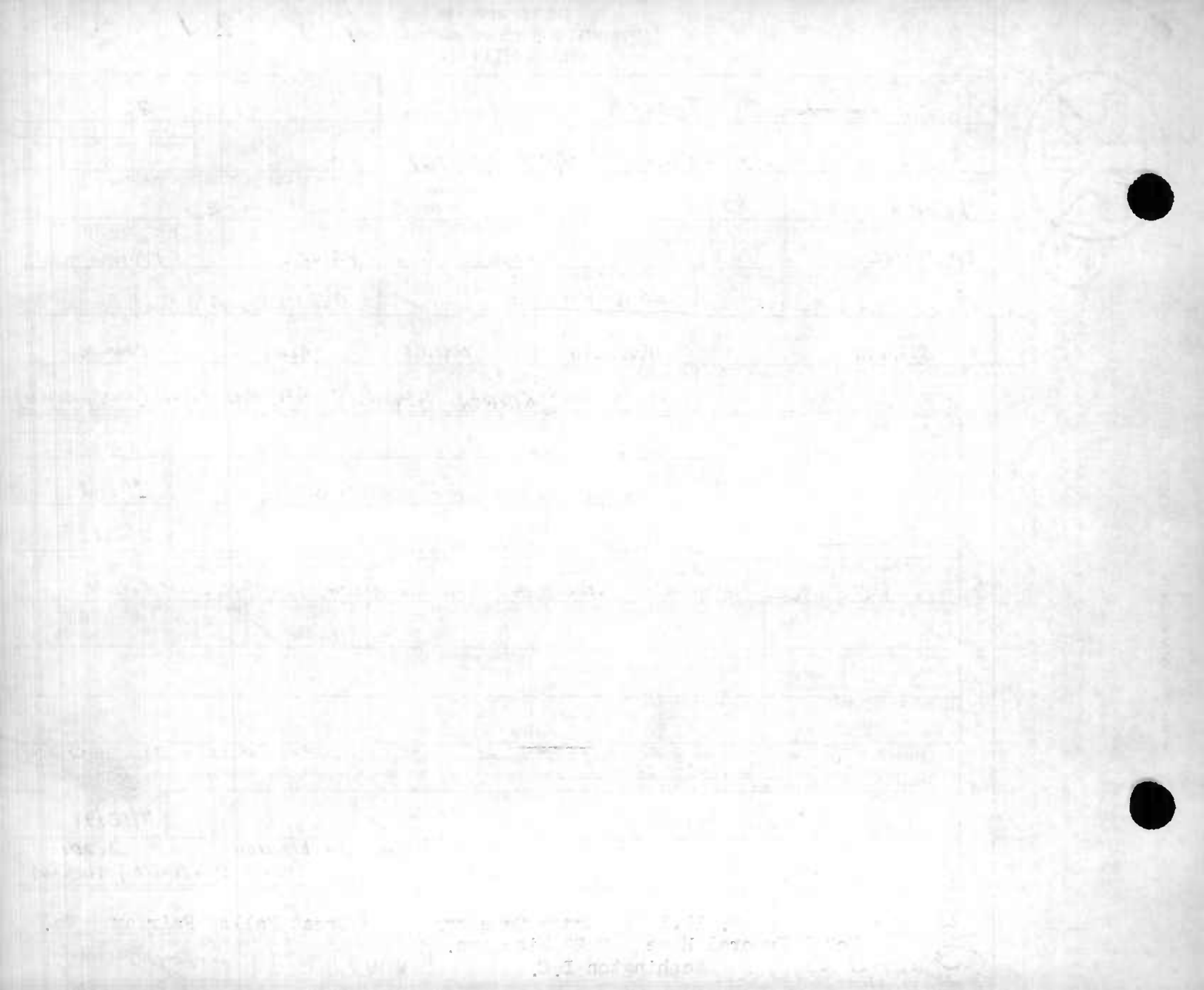
|  |  |  |  |  |  |
|--|--|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>PROBABLE METASTATIC CARCINOMA; CHRONIC ALCOHOLISM; MALNUTRITION</u>   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>STREET |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) this hospital attended the deceased from <u>OCTOBER 21</u> , 19 <u>79</u> , to <u>NOVEMBER 14</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 14</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br>Charles Brynry Elliott   |  |  |  | 22c. DATE SIGNED<br>11/15/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES G. ELLIOTT  |  |  |  | 22e. ADDRESS<br>PULMONARY DIVISION 20201<br>29 SOUTH BREENE STREET BALTIMORE, MARYLAND |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(a) (b) (c)<br>Burial   |  | 23b. DATE<br>Nov. 11, 1979   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arnon Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Great Falls Fairfax Va.  |
| 24. FUNERAL DIRECTOR'S NAME<br>Robert A. DeVol   |  |  | 24b. ADDRESS<br>2222 Wisc Ave.<br>Washington D.C.    |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1979   |
| 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR  
STATE  
REGISTRAR

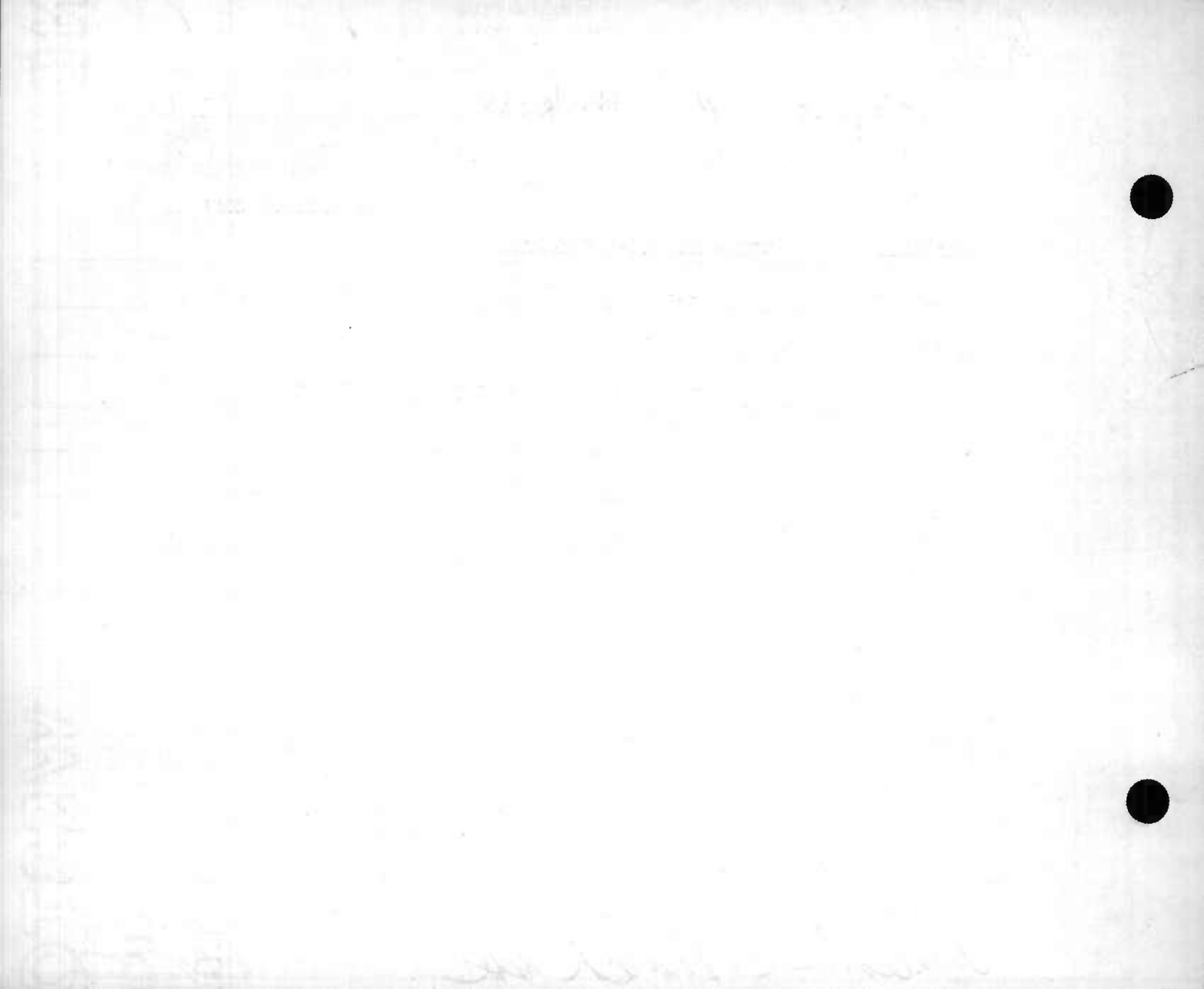
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 4 4 5

REG. NO.

|   |  |  |   |   |   |   |   |  |  |
|---|--|--|---|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret H. Hendricks  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 - 4 - 79                    |   |   | 2b. HOUR<br>11 A M  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 27 1926  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS                                 |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  |  | 13b. CITY OR TOWN<br>Baltimore  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13d. STREET ADDRESS<br>307 East 25th Street |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nathan P. Collins   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Gray            |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>219-20-6540 |   | 17. INFORMANT<br>ADDRESS<br>Adell Fennell 4215 Liberty Heights                                  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hepatic Failure<br>5712<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Alcoholic Cirrhosis, Rending Spleen<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Alcoholism<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION<br>10/23/79  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Bleeding Esophageal Varices  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/10, 1979, to 11/4, 1979, that (I) (we) last saw the deceased alive on 11/4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |   |   |   |   |   |  |  |
| 22b. SIGNATURE<br>Warren M. Ross MD   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   |   | 22c. DATE SIGNED<br>11/1/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WARREN M. ROSS   |  |  |   | 22e. ADDRESS<br>Union Mem Hosp  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/9/79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland         |   |  |  |
| 24. FUNERAL DIRECTOR<br>William C. March  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 6 1979   |   | 25b. REGISTRAR'S SIGNATURE<br>Dietrich Helms                              |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 9 2 7 4 4 6<br>REG. NO.  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  | 2b. HOUR   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Anna Marie Hennessey  |  |   |  | 11/06/79   |  |  |  | 3:30pM   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Sept 18, 1943  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, Maryland MD.                             |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Administrative Assist. |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Arthur A Hennessey  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nellie Myers   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-40-0846  |  | 17 INFORMANT ADDRESS<br>Mrs Nellie Hennessey Same  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Respiratory Failure</i><br>5028<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>DIFFUSE LYMPHOMA</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 8/26 19 79, to 11/6 19 79, that I (we) last saw the deceased alive on 11/6 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) did (and only view the body after death.  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Leonard J. Ruck</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |  |  | 22c. DATE SIGNED<br>11/6/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. G. Grew, MD   |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS ONCOLOGY CENTER  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/10/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens Of Faith   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                          |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>                                       |  |  |  |

001115





1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |                  |  |   |  |   |  |   |  |                               |  |   |  |                   |  |   |  |  |  |
|---|--|------------------|--|---|--|---|--|---|--|-------------------------------|--|---|--|-------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>DAVID   |  | MIDDLE<br>J.  |  | LAST<br>HENRY                                 |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED  |  | MONTH<br>11                   |  | DAY<br>9  |  | YEAR<br>1979      |  | 2b. HOUR<br>M                               |  |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCT. 8, 1933  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>46 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 9 1979   |  | 2d. HOUR<br>P. M. |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CURRIE, N.C.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. POST OFF.   |  |                               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                   |  |   |  |  |  |
| 13a. STATE<br>MARYLAND  |  |                  |  | 13b. COUNTY   |  |   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                   |  | 13e. STREET ADDRESS<br>813 N. PAYSON STREET |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EARL HENRY  |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY E. HENRY  |  |   |  |   |  |                               |  |   |  |                   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES.   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>VIETNAM  |  |   |  | 17. INFORMANT<br>ADDRESS<br>MRS. MARVA HENRY 813 N. PAYSON STREET   |  |                               |  |   |  |                   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4392<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |                  |  |   |  |   |  |   |  |                               |  |   |  |                   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |   |  |   |  |   |  |                               |  |   |  |                   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |                               |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |                   |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                               |  |   |  |                   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                               |  |   |  |                   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |                               |  |   |  |                   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><u>Hormez R. Guard</u>  |  |                  |  | TITLE (SPECIFY)<br>Assistant  |  |   |  | MEDICAL EXAMINER  |  |                               |  | DATE SIGNED<br>11/10/79   |  |                   |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |  |                  |  | ADDRESS<br>111 Penn Street, Balto., MD 21201  |  |   |  |   |  |                               |  |   |  |                   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |                  |  | 23b. DATE<br>11/16/79   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHURCH CEMETERY   |  |                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CURRIE, NORTH CAROLINA                            |  |                   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LEROY O. DYETT  |  |                  |  | 4600 LIBERTY HEIGHTS AVENUE   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1979  |  |                               |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony R. Brady</u>   |  |                   |  |   |  |  |  |



## MEDICAL CERTIFICATION

DHMH - 16 60M 1/75  
(VRA 15 (4))

|                               |                            |
|-------------------------------|----------------------------|
| 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|-------------------------------|----------------------------|



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   | 7 9 2 7 4 4 9  |  |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Vicki Ann HERNANDEZ</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/15/79</b>  |  | 2b. HOUR<br><b>6:26<sup>a</sup> AM</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 14, 1979</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>7 7</b>                               | IF UNDER 1 YEAR<br>IF UNDER 24 HRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>  | 13b. COUNTY <b>AA</b>  | 13c. CITY OR TOWN<br><b>Edgewater</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>1509 Bishop Road</b>                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Hernandez</b>   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbra Ann Dean</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                  |  |  |
| 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Father</b>  |   | ADDRESS<br><b>1509 Bishop Rd. Edgewater Md</b>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>7689</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>PROLONGED ASPHYXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs.</b><br><b>4 hrs.</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4 AM 11/15 19 79</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4 AM 11/15 19 79</b> , to <b>6:30 AM 11/15 19 79</b> , that (I) (we) last saw the deceased alive on <b>11/15/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |   |   |  |  |
| 22b. SIGNATURE<br><b>John T. Haley</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/15/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN T. FAHEY MD</b>  |  | 22e. ADDRESS<br><b>DEPT PEDIATRICS, JOHNS HOPKINS HOSP</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>Nov 17 79</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. P.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Blen Burnie AA Md.</b>        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James S. Kinley</b>  |  | ADDRESS<br><b>421 Crain Hwy. G.B.</b>   |   | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1979</b>                             |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John T. Haley</b>                             |  |



1200

*[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |              |   |                 |                                    |  | 7 9                                     | 2 7 4 5 0   |  |          |  |                 |  |               |  |          |  |
|--|--|--|---|--|--------------|---|-----------------|------------------------------------|--|---|-------------|--|----------|--|-----------------|--|---------------|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  |              |   |                 |                                    |  | REG. NO.                                |             |  |          |  |                 |  |               |  |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST<br>CARL   |  | MIDDLE<br>K. |   | LAST<br>HERSHEY |                                    | 2a. DATE OF DEATH  |   | MONTH<br>11 |  | DAY<br>3 |  | YEAR<br>79      |  | 2b. HOUR<br>7 |  | MIN<br>A |  |
| 3 SEX<br>M   |  |  | 4 RACE<br>W   |  |              | 5. DATE OF BIRTH  |                 |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)   |   |             | IF UNDER 1 YEAR  |          |  | IF UNDER 24 HRS |  |               |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |              | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City                           |   |             |  |          |  |                 |  |               |  |          |  |
| 10 CITY OR TOWN OF DEATH<br>BALTO.   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. OF MD. HOSPITAL |  |              |   |                 |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lab analyst |   |             | 12b. KIND OF BUSINESS OR INDUSTRY<br>Soap                                      |          |  |                 |  |               |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |              |   |                 |                                    |  | 13a. INSIDE CITY LIMITS?                |             | 13b. STREET ADDRESS  |          |  |                 |  |               |  |          |  |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Balto.   |  |              | 13c. CITY OR TOWN<br>Balto.   |                 |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                     |   |             | 731 Aldworth Road  |          |  |                 |  |               |  |          |  |
| 14 FATHER'S NAME   |  |  |   |  |              |   |                 |                                    |  | 15. MOTHER'S MAIDEN NAME                |             |  |          |  |                 |  |               |  |          |  |
| FIRST<br>CHARLES   |  |  | MIDDLE  |  |              | LAST<br>Hershey   |                 |                                    | FIRST<br>ALICE   |   |             | MIDDLE   |          |  | LAST<br>ALLISON |  |               |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  |  |   |  |              |   |                 |                                    |  | 16b. SOCIAL SECURITY NO.<br>215-18-7232 |             |  |          |  |                 |  |               |  |          |  |
| 17. INFORMANT  |  |  |   |  |              |   |                 |                                    |  | ADDRESS                                 |             |  |          |  |                 |  |               |  |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| PART 1. DEATH WAS CAUSED BY.   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| IMMEDIATE CAUSE (a) CARDIAC ARREST   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF PULMONARY EDEMA   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF HEART FAILURE 2° TO CORONARY DISEASE  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| MEDICAL CERTIFICATION  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| 19a. DATE OF OPERATION   |  |  |   |  |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                 |                                    |  |   |             | 20a. AUTOPSY?  |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                 |  |               |  |          |  |
|  |  |  |   |  |              |   |                 |                                    |  |   |             | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |          | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                 |  |               |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   |  |              | 21b. TIME OF INJURY   |                 |                                    |  |   |             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |          |  |                 |  |               |  |          |  |
|  |  |  |   |  |              | HOUR A.M. MONTH DAY YEAR  |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
|  |  |  |   |  |              | P.M. 19   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| 21d. INJURY OCCURRED   |  |  |   |  |              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                 |                                    |  |   |             | 21f. LOCATION  |          |  |                 |  |               |  |          |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   |  |              |   |                 |                                    |  |   |             | CITY OR TOWN COUNTY STATE  |          |  |                 |  |               |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/29 19 79 to 11/3 19 79, that (I) (we) lost saw the deceased alive on 11/3 19 79, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| 22b. SIGNATURE   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| DEGREE   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| 22c. DATE SIGNED   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| 11/3/79  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| SCOTT D. FRIEDMAN MD   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| 22e. ADDRESS   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| UNIV. OF MD. HOSP. 22 S. Greene St Balto., Md.   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |   |  |              | 23b. DATE   |                 | 23c. NAME OF CEMETERY OR CREMATORY |  |   |             | 23d. LOCATION  |          |  |                 |  |               |  |          |  |
| Removal  |  |  |   |  |              | 11/3/79   |                 |                                    |  |   |             | CITY OR TOWN COUNTY STATE  |          |  |                 |  |               |  |          |  |
| 24 FUNERAL DIRECTOR  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| NAME   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| Anatomy Board  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| ADDRESS  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| Balto., Md.  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| 25a. DATE REC'D. BY REGISTRAR  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| NOV 09 1979  |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |
| Ruthy McCreedy   |  |  |   |  |              |   |                 |                                    |  |   |             |  |          |  |                 |  |               |  |          |  |

14



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the body be kept in the hospital or with the attending physician for 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the body be kept in the hospital or with the attending physician for 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the body be kept in the hospital or with the attending physician for 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |  |  |  |   |              |  |
|---|--|--|---|---|--|--|--|---|--------------|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   | 7 9 27451  |  |  |   |              |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |   |   | 2a. DATE OF DEATH  |  |  |   |              |  |
| RUTH HERSTEIN   |  |  |   |   | NOV. 1, 1979   |  |  |   |              |  |
| 3 SEX   |  | 4 RACE   |   | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7b. HOUR  |              |  |
| FEMALE  |  | WHITE  |   | MAR. 2, 1909  |  | 70 YRS.  |  | 9:00 P.M.   |              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |              |  |
| MARYLAND  |  | USA  |   |   |  | BALTIMORE CITY MD  |  |   |              |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |              |  |
| BALTIMORE   |  | JOHNS HOPKINS HOSPITAL   |   | SELF-EMPLOYED   |  | L.A. HERSTEIN CO.  |  |   |              |  |
| 13a. STATE  |  |  |   |   | 13b. COUNTY  |  |  |   |              |  |
| MARYLAND  |  |  |   |   | BALTIMORE  |  |  |   |              |  |
| 14 FATHER'S NAME  |  |  |   |   | 15 MOTHER'S MAIDEN NAME  |  |  |   |              |  |
| JOSEPH MIDDLE LAST SACHS  |  |  |   |   | REBECCA MIDDLE LAST GLASS  |  |  |   |              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |   |   | 16b. SOCIAL SECURITY NO  |  |  |   |              |  |
| NO  |  |  |   |   | 212-05-4847  |  |  |   |              |  |
| 17 INFORMANT  |  |  |   |   | ADDRESS  |  |  |   |              |  |
| LOUIS HERSTEIN III  |  |  |   |   | 2722 HANSON AVE. #21209  |  |  |   |              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |   |  |  |  |   |              |  |
| IMMEDIATE CAUSE (a) HYPERKALEMIA  |  |  |   |   |  |  |  |   |              |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) LYMPHOMA   |  |  |   |   |  |  |  |   |              |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |   |  |  |  |   |              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |  |  |   |              |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |              |  |
|   |  |  |   |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |              |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION  |  |   |              |  |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   |   |  | CITY OR TOWN   |  |   | COUNTY STATE |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/25, 19 79, to 11/1, 19 79, that (I) (we) last saw the deceased alive on 11/1, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |   |              |  |
| 22b. SIGNATURE  |  |  |   |   | DEGREE   |  |  | 22c. DATE SIGNED  |              |  |
| Alan L. Silverberg M.D.   |  |  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 11/1/79   |              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |   | 22e. ADDRESS   |  |  |   |              |  |
| ALAN L. SILVERBERG  |  |  |   |   | JOHNS HOPKINS HOSPITAL   |  |  |   |              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION   |              |  |
| BURIAL  |  |  | NOV. 4, 1979  |   | MIKRO KODESH BETH ISRAEL   |  |  | BALTIMORE CITY MARYLAND   |              |  |
| 24 FUNERAL DIRECTOR   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR  |  |  |   |              |  |
| SOL LEVINSON & BROS., INC.  |  |  |   |   | NOV 8 1979   |  |  |   |              |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |   |   | 25b. REGISTRAR'S SIGNATURE   |  |  |   |              |  |
|   |  |  |   |   | Ruth Herstein  |  |  |   |              |  |

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

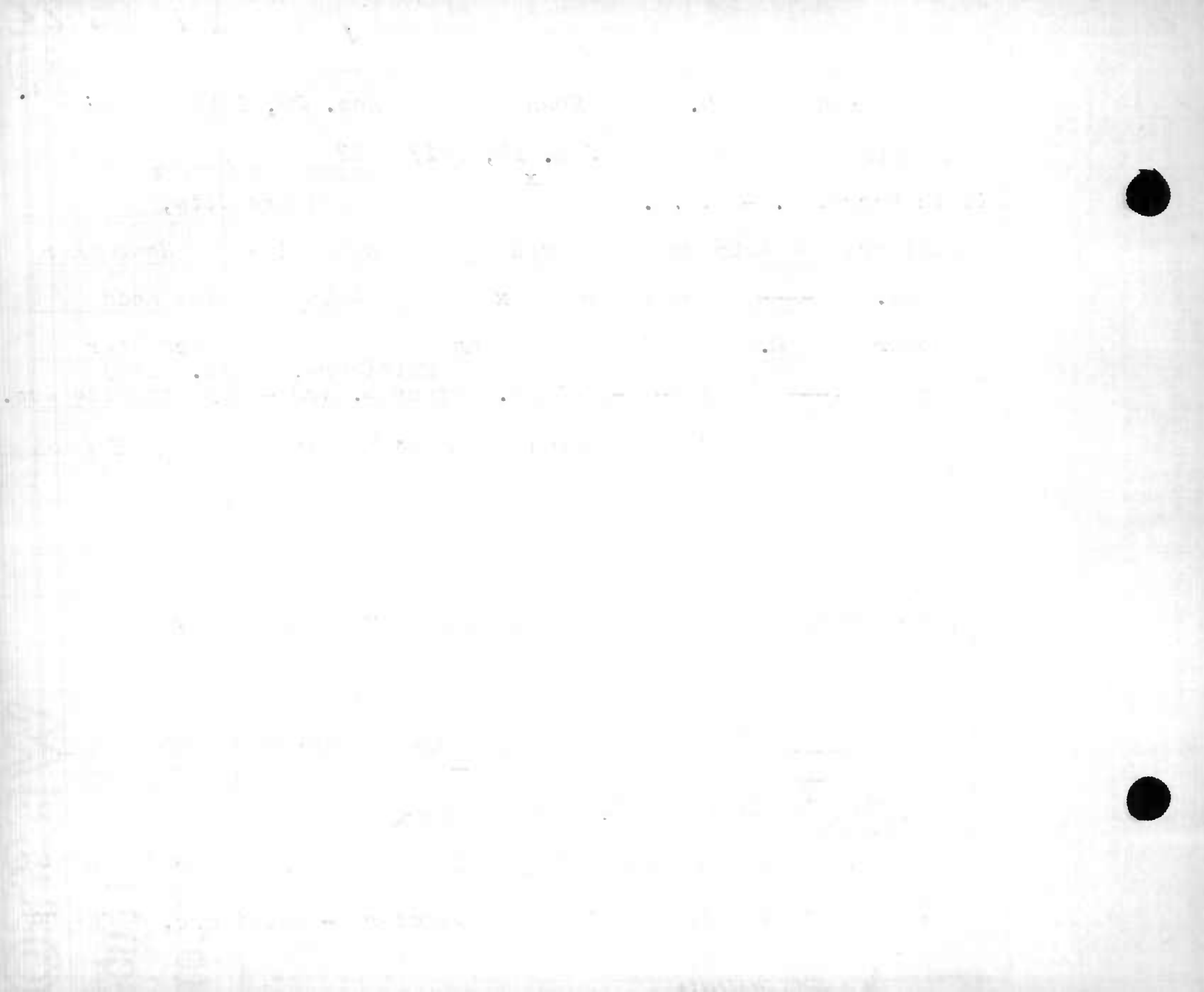
7 9 2 7 4 5 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |                                       |  |   |   |  |  |
|---|--|--|---|--|---------------------------------------|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ann D. Hess</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 27, 1979</b> |  |                                       | 2b. HOUR<br>MIN.<br><b>1:30 A.M.</b>   |   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 13, 1917</b>   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>62</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wilkes Barre, Pa. - U.S.A.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                           |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4805 Woodside Road</b> |   |  |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>         |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b>   |  |  |
| 13a. STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>----</b>                                  |  | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>4805 Woodside Road</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gomer R. Davis</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ann McMaster</b>   |                                       |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>177-05-1182</b>  |                                       | 17. INFORMANT<br><b>Baltimore, Md. 21229</b><br><b>Mr. Arthur E. Hess-4805 Woodside Ave.</b> |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>ENDOMETRIAL CARCINOMA</b><br><b>1820</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |  |                                       |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |   |  |                                       |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>1977-1979</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Same-Endometrial Carcinoma</b>  |   |  |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                       |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                       |  |   |   |  |  |
| 22. I certify that (I) (the hospital) attended the deceased from <b>JAN 1965</b> to <b>Nov 27, 1979</b> , that (I) (we) last saw the deceased alive on <b>Nov 25, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |  |   |  |                                       |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Martin E. Singewald</b>  |  |  |   | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                       |  |   | 22c. DATE SIGNED<br><b>11-27-79</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN E. SINGEWALD MD</b>  |  |  |   | 22e. ADDRESS<br><b>11 E. CHASE ST BALTIMORE MD 21202</b>   |                                       |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>11/30/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery - Baltimore, Maryland</b>  |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Sterling Funeral Estate</b><br><b>736 Edmondson Ave.</b><br><b>Catonsville, Md. 21228</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1979</b>   |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. McCreedy</b>  |   |   |  |  |

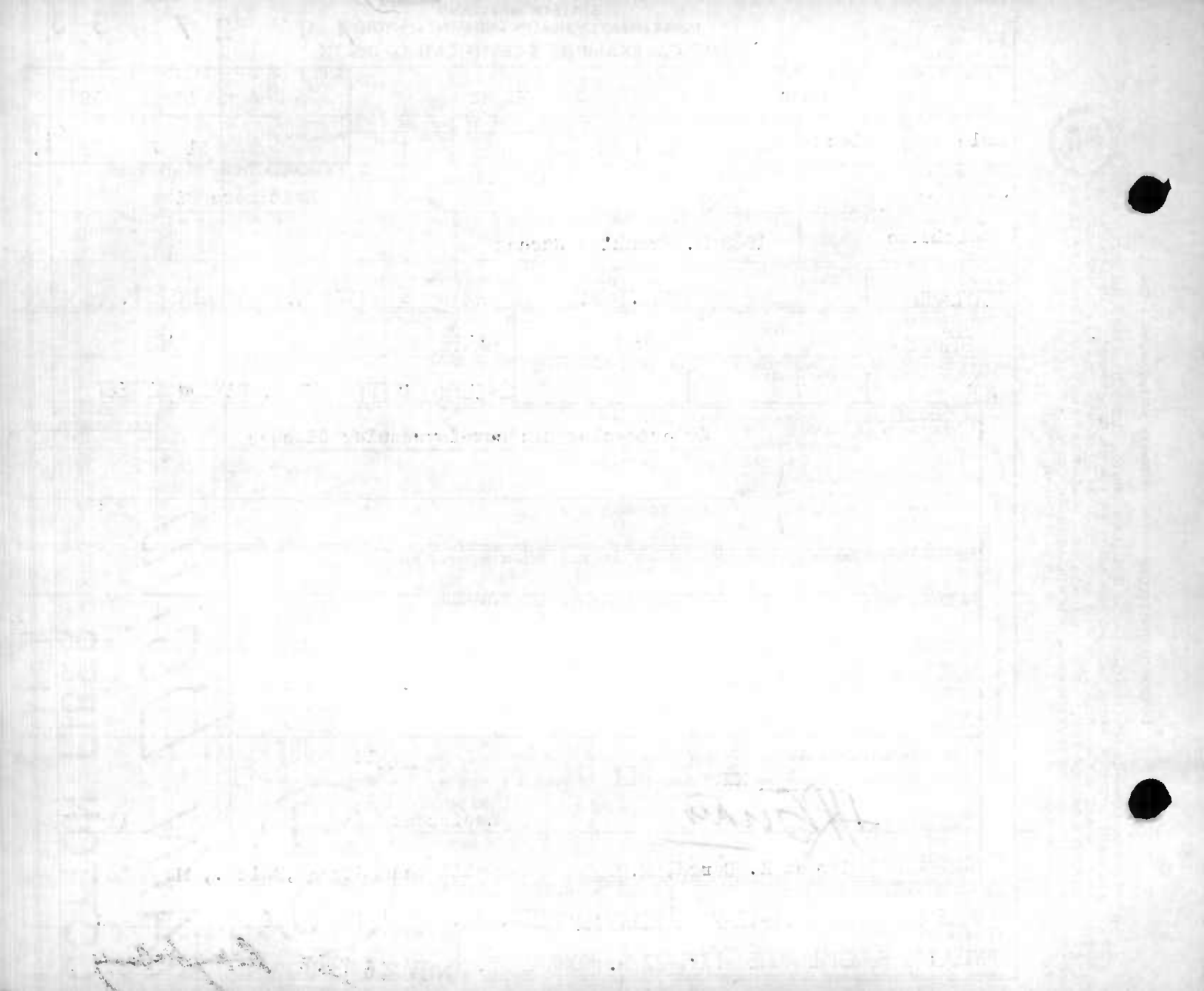
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |   |                                |   |  |   |  | REG. NO. 7 9 2 7 4 5 3 |  |
|--|-------------------------|--|---|---|--------------------------------|---|--|---|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Otha High</b>   |                         |  |   |   |                                | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 6 19 79</b> |  | 2b. HOUR <b>M</b>   |  |                        |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6- 4 18</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>61</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>11 7 19 79</b>  |  | 2d. HOUR <b>2:18 a.m.</b>   |  |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1948 W. Franklin Street</b> |   |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                        |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1948 W. FRANKLIN ST.</b>  |                         |  |   |   |                                |   |  |   |  |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>STUBBS HIGH</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARIE PACE</b>  |                                |   |  |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><b>EVELYN PRETTY 323 N. PAYSON STREET</b>  |                                |   |  |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |   |   |                                |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |                         |  |   |   |                                |   |  |   |  |                        |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                                |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                        |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                |   |  |   |  |                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |  |   |  |                        |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                         |  |   |   |                                |   |  |   |  |                        |  |
| ACTUAL SIGNATURE <b>JRG</b>  |                         | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER   |   | DATE SIGNED <b>11/7/79</b>  |                                |   |  |   |  |                        |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |                         | ADDRESS <b>111 Penn Street, Balto., MD 21201</b>   |   |   |                                |   |  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>11-12-79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW MEM. PK.</b>  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                                   |  |   |  |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>PHILLIPS FUNERAL HOME</b> ADDRESS <b>1721-27 N. MONROE ST.</b>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                |   |  |   |  |                        |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |   |  | 7 9      | 2 7 4 5 4 |
|--|--|---|--|---|--|--|--|---|--|----------|-----------|
| 1 - FOR STATE REGISTRAR  |  |   |  |   |  |  |  |   |  | REG. NO. |           |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RICHARD PRESHING HIGHSMITH</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 25 79</b>   |  | 2b. HOUR<br><b>8:24a</b>  |  |          |           |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 11 18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |          |           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY,</b> MD  |  |   |  |          |           |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>V.A.M.C. 3900 LOCH RAVEN BLVD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chauffeur</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Taxi</b>  |  |          |           |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>501 DARKHEAD RD 21220</b>   |  |          |           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES R. HIGHSMITH</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LILLIAN GORDON</b>  |  |  |  |   |  |          |           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>  |  | 17. INFORMANT<br><b>VAMC, Clinical Records Balto, Md. 21218</b>   |  | ADDRESS  |  |   |  |          |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>5728</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hepatic Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |   |  |          |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |   |  |   |  |  |  |   |  |          |           |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |          |           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |          |           |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 25 19 79</b> to <b>NOVEMBER 25 19 79</b> , that (I) (we) saw the deceased alive on <b>NOVEMBER 25 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |   |  |  |  |   |  |          |           |
| 22b. SIGNATURE<br><b>E. Timothy Souweine MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |          |           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. Timothy Souweine MD</b>   |  |   |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD Balto, Md 21218</b>   |  |  |  |   |  |          |           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/27/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A. Co., Maryland</b>   |  |   |  |          |           |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony M. Brady</b>  |  |   |  |          |           |

A.E.U.

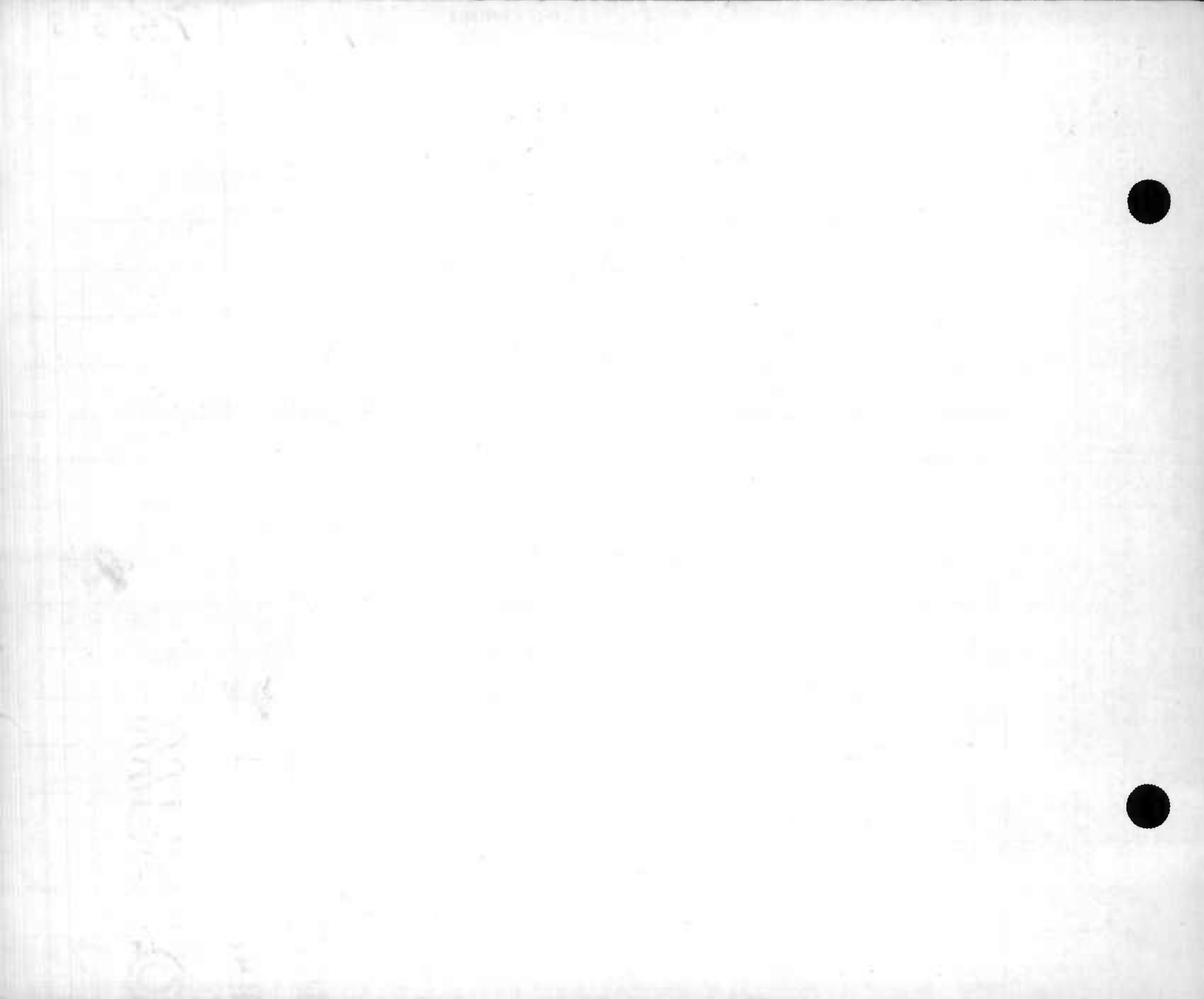


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |   | 79 27455  |  |
|---|---|---|---|---|--|
| 1. FOR STATE REGISTRAR  |   |   |   | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ALVIN L HILL   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-24-79                             |   | 2b. HOUR<br>6:20 (A)                         |
| 3. SEX<br>MALE  | 4. RACE<br>BLK  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 5 47  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>32 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALT   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS HOSP. |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNEMPLOYED |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |   | 13b. COUNTY<br>—  | 13c. CITY OR TOWN<br>BALT   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ARTHUR HILL   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARGARET BASSOWAY          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>UNKNOWN  |   | 16b. SOCIAL SECURITY NO.<br>218-46-8707   |   | 17. INFORMANT<br>S. Barnes Lynn B.S. Hosp.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u><br>5711<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATIC ENCEPHALOPATHY</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ALCOHOLIC HEPATITIS</u><br><u>CHB. KIDNEY ARTERY</u> |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>11-17-1979</u> , to <u>11-24-1979</u> , that (1) (we) last saw the deceased alive on <u>11-24-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Asad Khan</u>  |   |   |   | 22c. DATE SIGNED<br>11-24-79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ABDUL SAMAD KHAN   |   |   |   | 22e. ADDRESS<br>BON SECOURS HOSPITAL BAL. MD  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>Nov 29   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cemetery                                      |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Brooklyn Pk. AA. Co.   |   | 23e. COUNTY<br>Baltimore  |   | 23f. STATE<br>Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Powell F/H 319 North Schroeder St.  |   |   |   | 25a. DATE REC'D BY REGISTRAR<br>NOV 28 1979   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |   |   |   |  |

BP

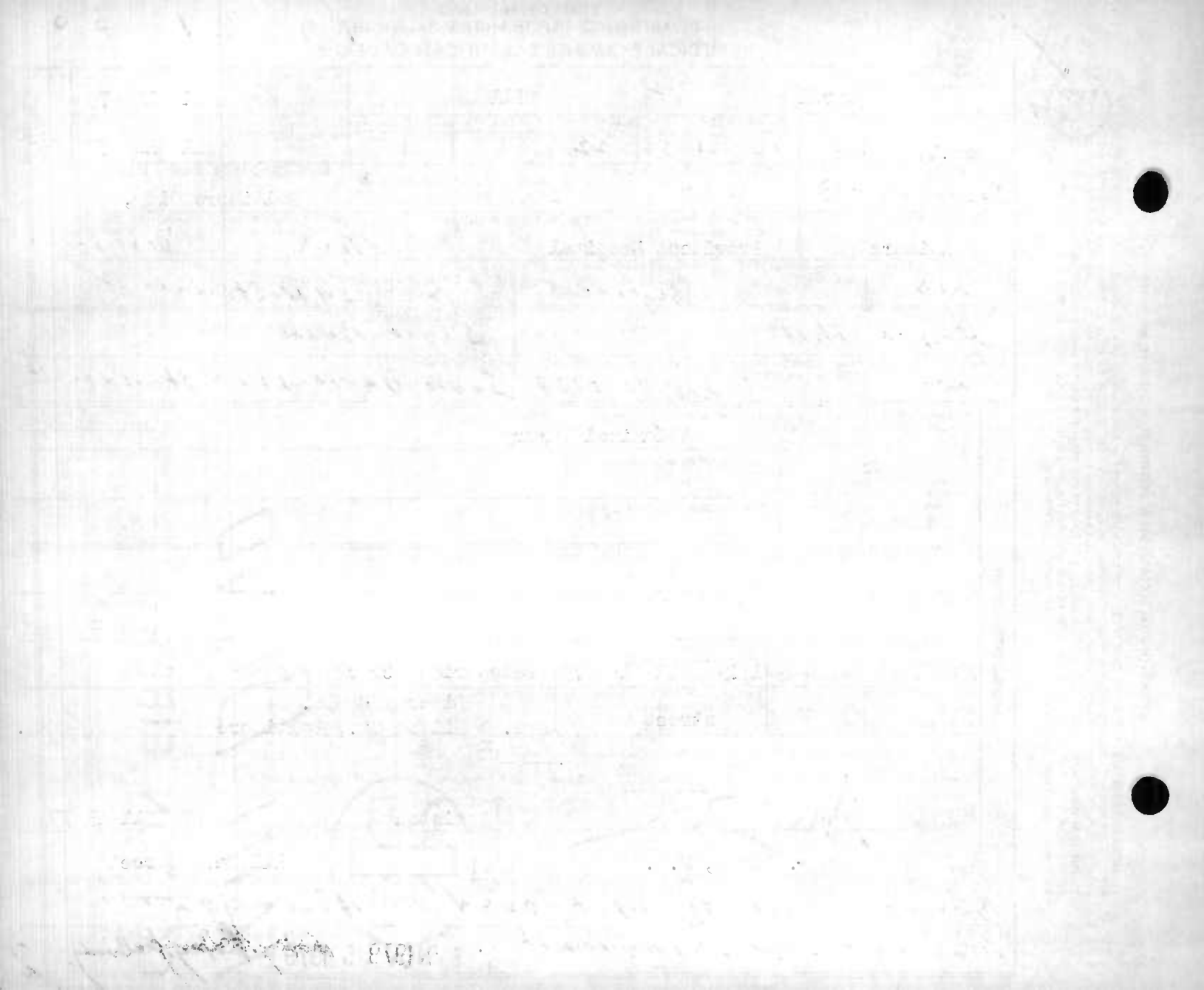


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE AN EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PA 3, RETAIN PAGE 5 FOR YOUR FILES. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF INVESTIGATION CASE, GIVE PAGES 1, 2, AND 3 TO THE BUREAU OF INVESTIGATION. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF INVESTIGATION CASE, GIVE PAGES 1, 2, AND 3 TO THE BUREAU OF INVESTIGATION. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF INVESTIGATION CASE, GIVE PAGES 1, 2, AND 3 TO THE BUREAU OF INVESTIGATION.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | REG. NO. 27456                               |  |
|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Carolyn F Hill                                    |  |  |  |  |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR                                     |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH (MONTH DAY YEAR)  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.                                       |  | 2c. DATE PRONOUNCED DEAD                     |  |
| Female   |  | Black   |  | 12 21 56   |  | 22 YRS.  |  |  |  | 11 12 1979                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| Baltimore City MD  |  | USA   |  |  |  | Baltimore City, MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Baltimore  |  | Provident Hospital  |  |  |  | Clock  |  | Dept Store   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS  |  |  |  |
| MD   |  |   |  | Baltimore  |  |  |  | 524 N. SHICKLER ST   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |
| Lester Hill  |  |   |  | Sadie Bush   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |
| NO   |  |   |  | 218-70-5739  |  | Sadie Davis 524 N. SHICKLER ST   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Abdominal Injury<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |  |  |
|  |  |   |  | 1:15 P.M. 11 12 1979   |  | Pedestrian struck by auto  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
|  |  |   |  | street   |  | Liberty Hgts. Ave. & Hilton St., Baltimore Md.   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE   |  |   |  | TITLE (SPECIFY)  |  |  |  | DATE SIGNED  |  |  |  |
| Ann M. Dixon, M.D.   |  |   |  | Assistant  |  |  |  | 11/13/79   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |   |  | ADDRESS  |  |  |  |  |  |  |  |
| Ann M. Dixon, M.D.   |  |   |  | 111 Penn Street  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| Burial   |  | 11/17/79  |  | Wheaton  |  | Baltimore MD 21230   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Marion H. Jones  |  |   |  | NOV 15 1979  |  |  |  | [Signature]  |  |  |  |

1602



## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |   |  |   |
|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HAGLAND, Gertrude E.  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 20, 1979   |  | 2b. HOUR<br>11 M  |
| 3. SEX<br>Female   | 4. RACE<br>Cauc   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 29, 1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83<br>YRS MONTHS DAYS HOURS MIN                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Kenesaw Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>Md.  |   | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Balto.                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Poplar   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sally Brown  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>197-09-0562   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Joan Eifert - 5310 Holder Avenue-21214                         |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular accident<br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Anterior Cerebral Artery thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) A.C.V.D. |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>0   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/4, 1979, to 11/20, 1979, that (I) (we) lost<br>saw the deceased alive on 10/20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |  |   |
| 22b. SIGNATURE<br>Edward Obunk   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br>11/20/79  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>F. O. NUNY  |   | 22e. ADDRESS<br>2300 Garrison Blvd 21216  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>11-23-79   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John C. Miller Inc-6415 Belair Rd.-21206   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1979  |  |   |
| 25b. REGISTRAR'S SIGNATURE<br>Hirshy McCreedy  |   |   |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

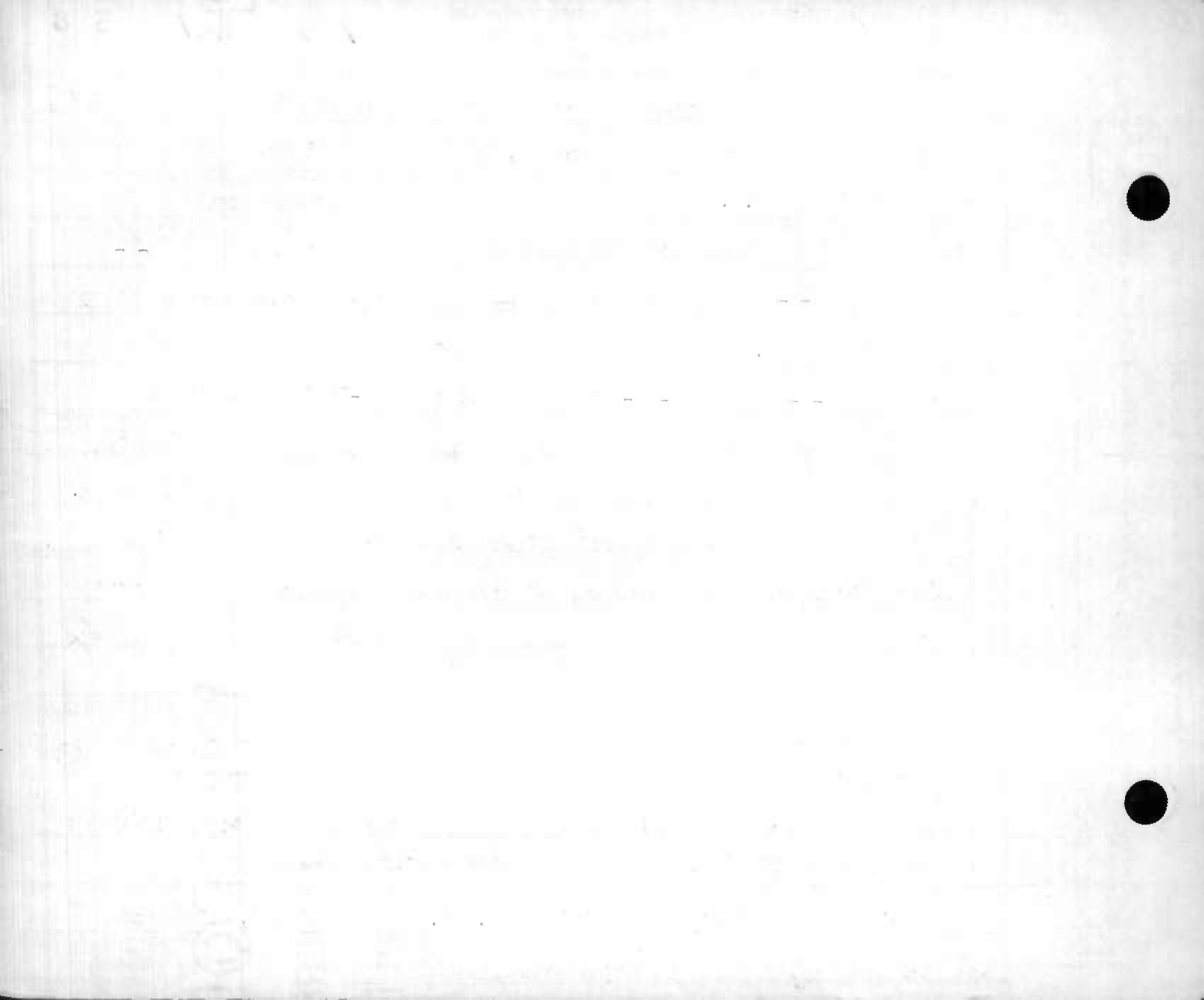


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |  |  | REG. NO.  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN Allen HOBAN  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-29-79   |  |  |  | 2b. HOUR<br>8 35 A.M.  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 14, 1916   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 yrs  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13b. STREET ADDRESS<br>3613 Roland Avenue (21211)                                    |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>-   |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Timothy J. Hoban   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maude Buckley  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-05-6187   |  | 17. INFORMANT<br>ADDRESS<br>Katherine Hoban-3613 Roland Avenue  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis<br>2387 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) pancytopenia<br>(c) myeloproliferative disorder<br>DUE TO, OR AS A CONSEQUENCE OF<br>28 days<br>1 yr                          |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>48 hrs  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>CHF COPD anemia bleeding 2° thrombocytopenia  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 31, 1979, to Nov 29, 1979, that (I) (we) lost saw the deceased alive on Nov 29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Lalah Newbrough MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>11-29-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LALAH NEWBROUGH, M.D.   |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>12/1/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>a a leitz  |  |  |  | ADDRESS<br>3818-Roland Ave  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Pietro McCreedy  |  |





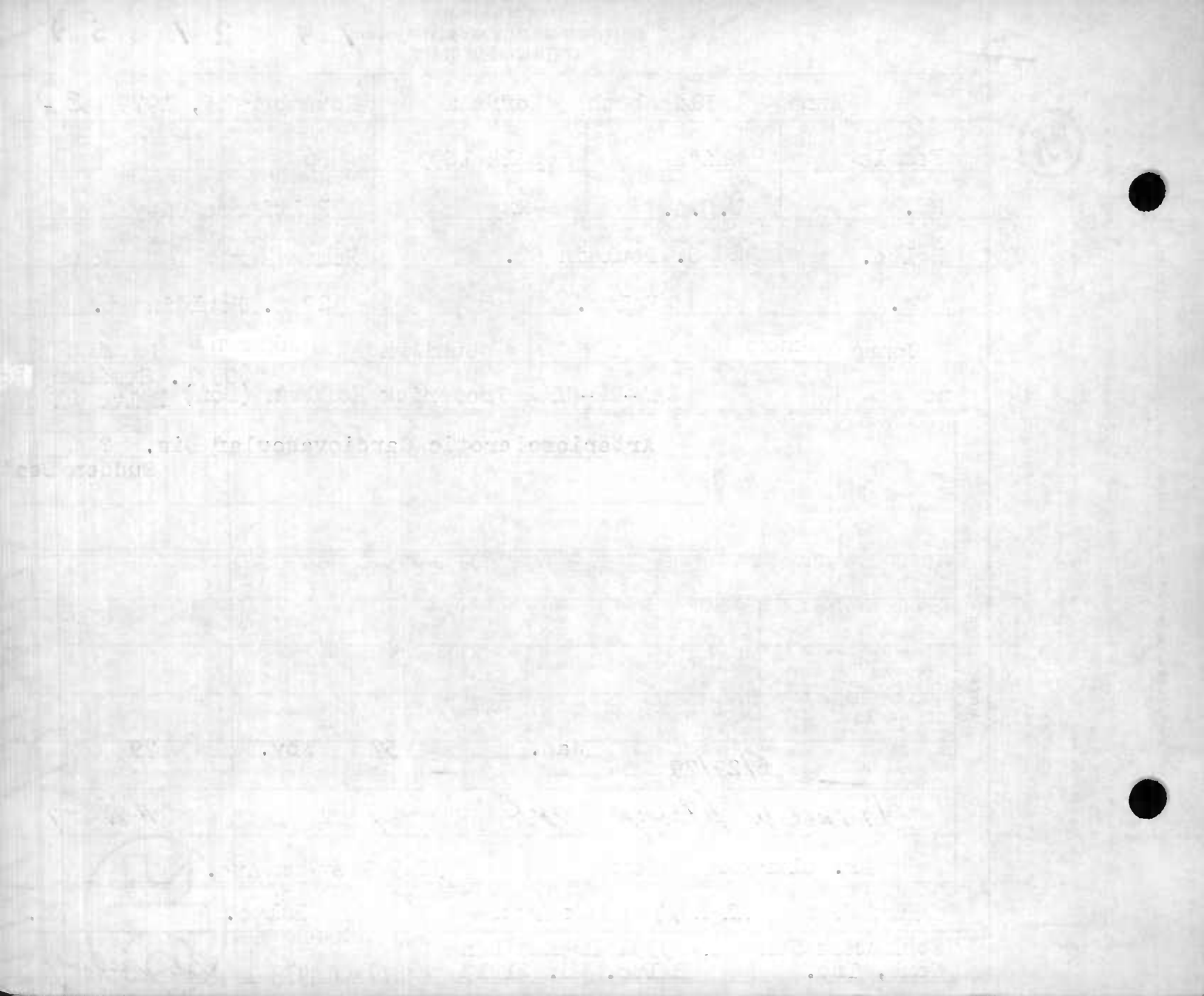
|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Anna Elizabeth Hoffman   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 15, 1979 |   |  | 2b. HOUR<br>2A M  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sep 14 1893   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>329 S. Bouldin St. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>329 S. Bouldin St.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Conrad Draude   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST LAST<br>Cunigunde Schmidt   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>214-22-5144   |  | 17. INFORMANT<br>ADDRESS<br>609 E. Seminary Ave.<br>Balto 21204   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Dis. ?<br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) Sudden Death<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 57, to Nov. 19 79, that (I) (we) last saw the deceased alive on 6/29/79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Clarence W. LeDoux, M.D.  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>11-16-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Clarence LeDoux  |  |   |  | 22e. ADDRESS<br>3023 Eastern Ave.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/19/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.  |  |   |  | 3331 Brehms Lane<br>Balto. Md. 21213  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. Helms  |  |

FOR  
STATE  
REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   |   |   |   |   |  | 7   | 9 | 2  | 7        | 4 | 6 | 0 |
|--|--|--|---|---|---|---|---|---|--|---|---|--|----------|---|---|---|
| 1. FOR STATE REGISTRAR   |  |  |   |   |   |   |   |   |  | REG. NO.  |   |  |          |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>BEATRICE M. HOFFMAN</b>   |  |  |   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>07</b> YEAR <b>79</b>                     |   |   |   |  | 2b. HOUR<br><b>9:59 a.m.</b>                              |   |  |          |   |   |   |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>05</b> YEAR <b>06</b>  |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS                                |   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>            |   | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b> |          |   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.               |   |  |   |   |  |          |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL - E.R.</b> |   |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MANUFACTURING</b> |   |  |          |   |   |   |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>LANSDOWNE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>223 ELIZABETH AVENUE, 21227</b>                     |  |   |   |  | OF BOXES |   |   |   |
| 14. FATHER'S NAME<br>FIRST <b>HARRY</b> MIDDLE <b></b> LAST <b>KROEDEL</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>BEATRICE</b> MIDDLE <b></b> LAST <b>FINNESSY</b> |   |   |   |  |   |   |  |          |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-07-1895</b>  |   | 17. INFORMANT ADDRESS<br><b>HALBERT L. HOFFMAN, 223 ELIZABETH AVENUE</b>                        |   |   |  |   |   |  |          |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line, but add (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4149 Cardiac respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced COPD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b>                                   |  |  |   |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |   |  |          |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |   |   |   |   |  |   |   |  |          |   |   |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |          |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |   |  |   |   |  |          |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |   |  |          |   |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |   |   |   |  |   |   |  |          |   |   |   |
| 22b. SIGNATURE<br><b>MIGUEL A. HEREDIA, M.D.</b>   |  |  |   |   |   | 22c. DATE SIGNED<br><b>11/9/79</b>  |   |   |  |   |   |  |          |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |   |   | 22e. ADDRESS<br><b>413 COMMONWEALTH AVENUE, 21228</b>   |   |   |  |   |   |  |          |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>11-10-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>                     |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b> |  |   |   |  |          |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.</b>   |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony Heredia</b>                          |  |   |   |  |          |   |   |   |



*Handwritten text, possibly a signature or date, appearing upside down.*



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

2 7 4 6 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |   |  |  |  |
|--|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN M HOFFMAN</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-29-79</b>                    |   |  | 2b. HOUR<br><b>7:15 AM</b>   |   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/30/26</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NH</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO CITY HOSP</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b>   |  |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>ESSEX</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>823 BRUNSWICK</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ARTHUR BUTTINE</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNK</b>            |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>052 22 864</b>                          |   | 17. INFORMANT<br>ADDRESS<br><b>SUSAN FORSTER BK625A ROSALIE AVE</b>            |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Cancer, source unknown</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/13</b> , 19 <b>79</b> , to <b>11/29</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/29</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>P. Richman MD</b>   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/29/79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL RICHMAN</b>   |  |   | 22e. ADDRESS<br><b>BALTO CITY HOSP 4940 EASTERN AVE</b>                |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>12/1/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>   |  |   | ADDRESS<br><b>300 MACE</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McBrady</b>  |  |  |

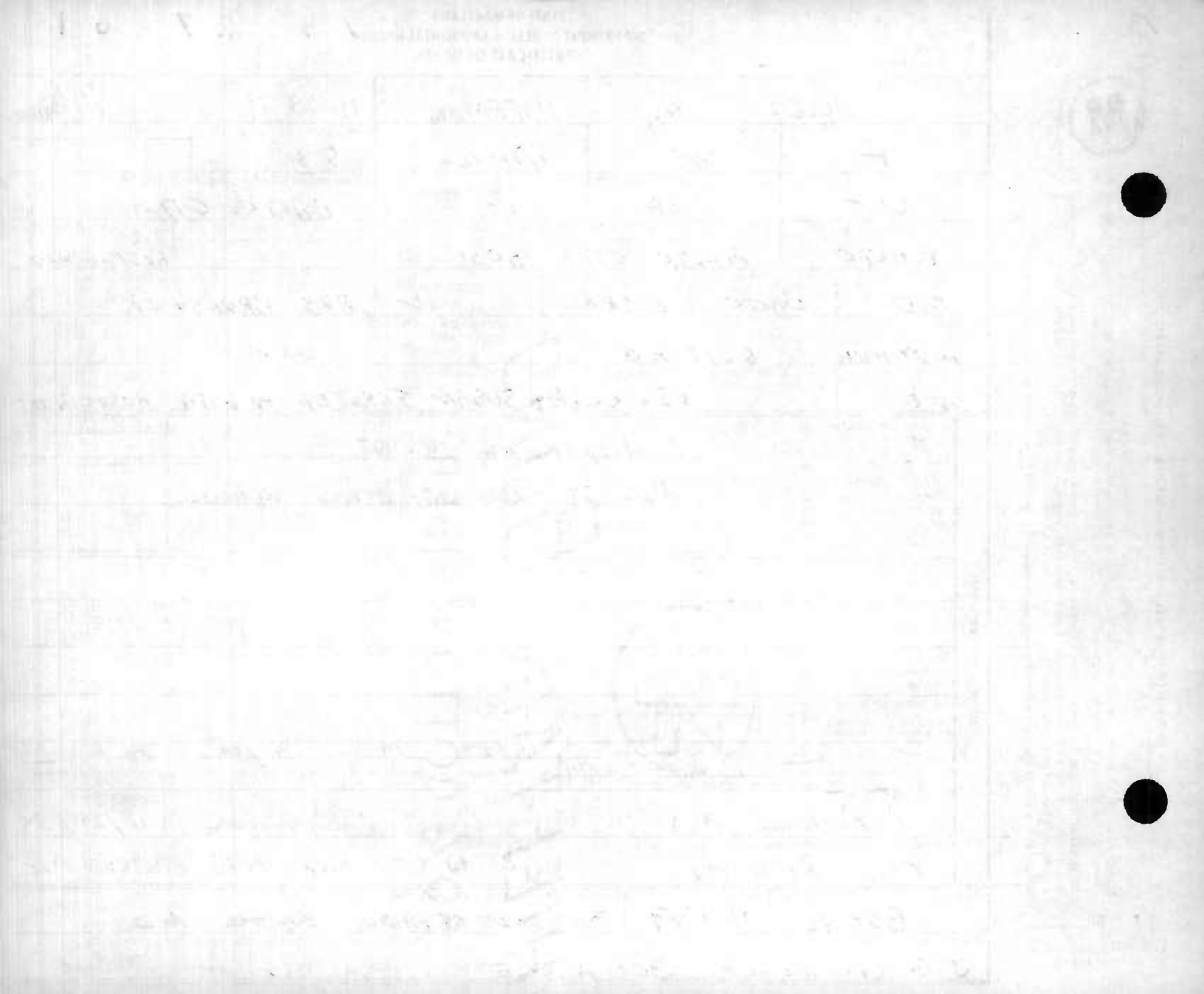
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



6

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

2 7 4 6 2

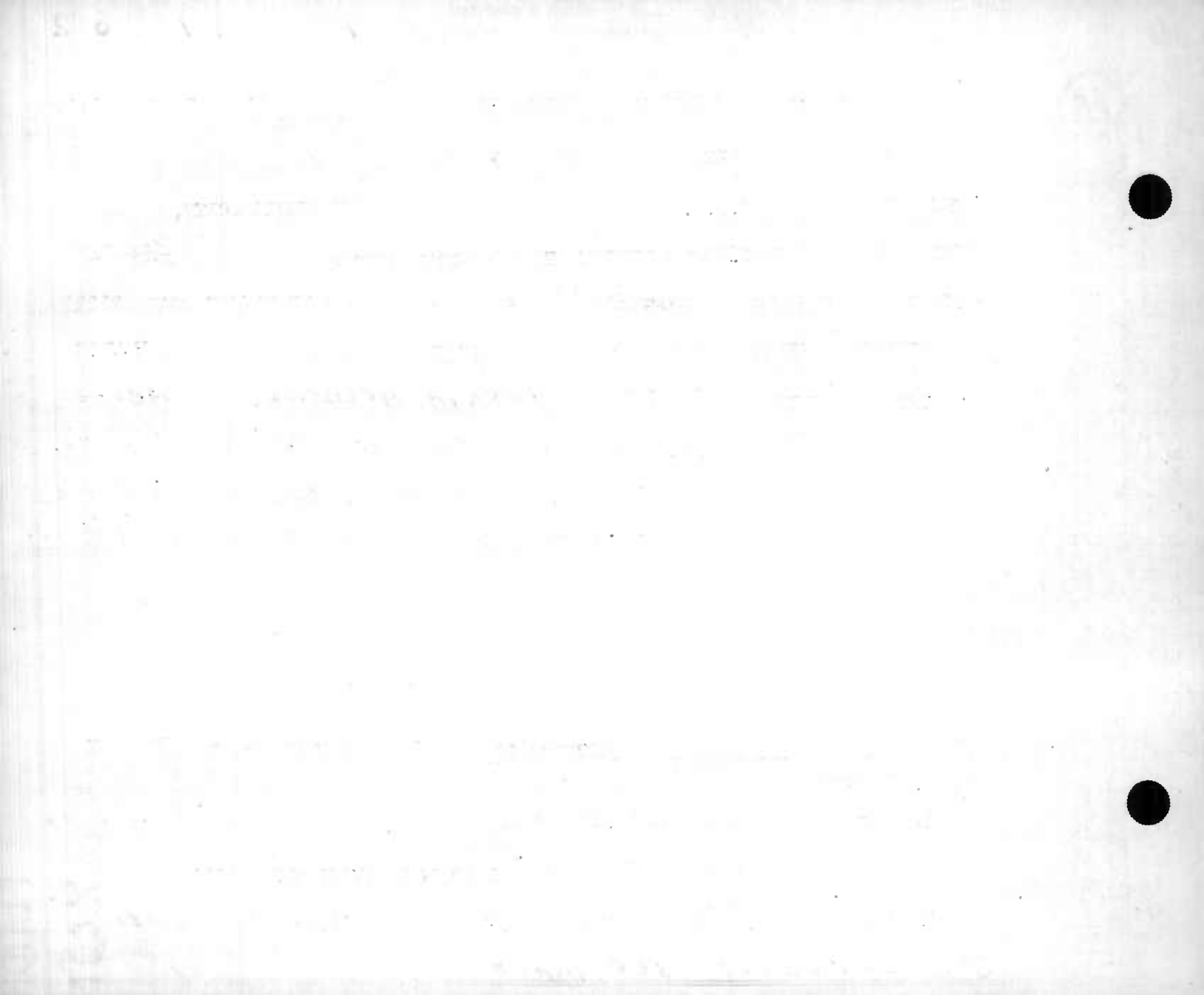
REG. NO.

|   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE WILLIAM HOLBROOK</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 7 79</b>              |  |   | 2b. HOUR<br><b>11:10pm</b>   |  |  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 14 15</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS                                      |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KENTUCKY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.              |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FENCE</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. CITY OR TOWN<br><b>BALTO</b>                                  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>668 MIDDLESEX ROAD 21221</b> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM RILEY HOLBROOK</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY TAYLOR</b> |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>404037088</b>   |  | 17 INFORMANT<br><b>VERNIA HOLBROOK</b>   |   |  | ADDRESS<br><b>ABOVE</b>                                |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE - ARREST</b><br>185-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>POSSIBLE PULMONARY EMBOLUS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PROSTATIC CARCINOMA - METASTATIC</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 HR</b><br><b>? 1 HR</b><br><b>1 1/2 YRS</b> |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>11-5-79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>HEMORRHOIDS</b>   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>OCTOBER 30</b> , 19 <b>79</b> , to <b>NOVEMBER 7</b> , 19 <b>79</b> , that (we) (we) lost saw the deceased alive on <b>NOVEMBER 7</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (we) view the body after death.   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Christine L. Commerford MD</b>   |  |  |  | DEGREE<br><b>MD</b>  |   |  |  | 22c. DATE SIGNED<br><b>11-8-79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHRISTINE L. COMMERFORD MD</b>  |  |  |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/10/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLLY HILL</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                      |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>J. G. CONNELLY</b>  |  |  |  | ADDRESS<br><b>300 MACE</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM-16 20M  
(VRA 15, 4) 7/78

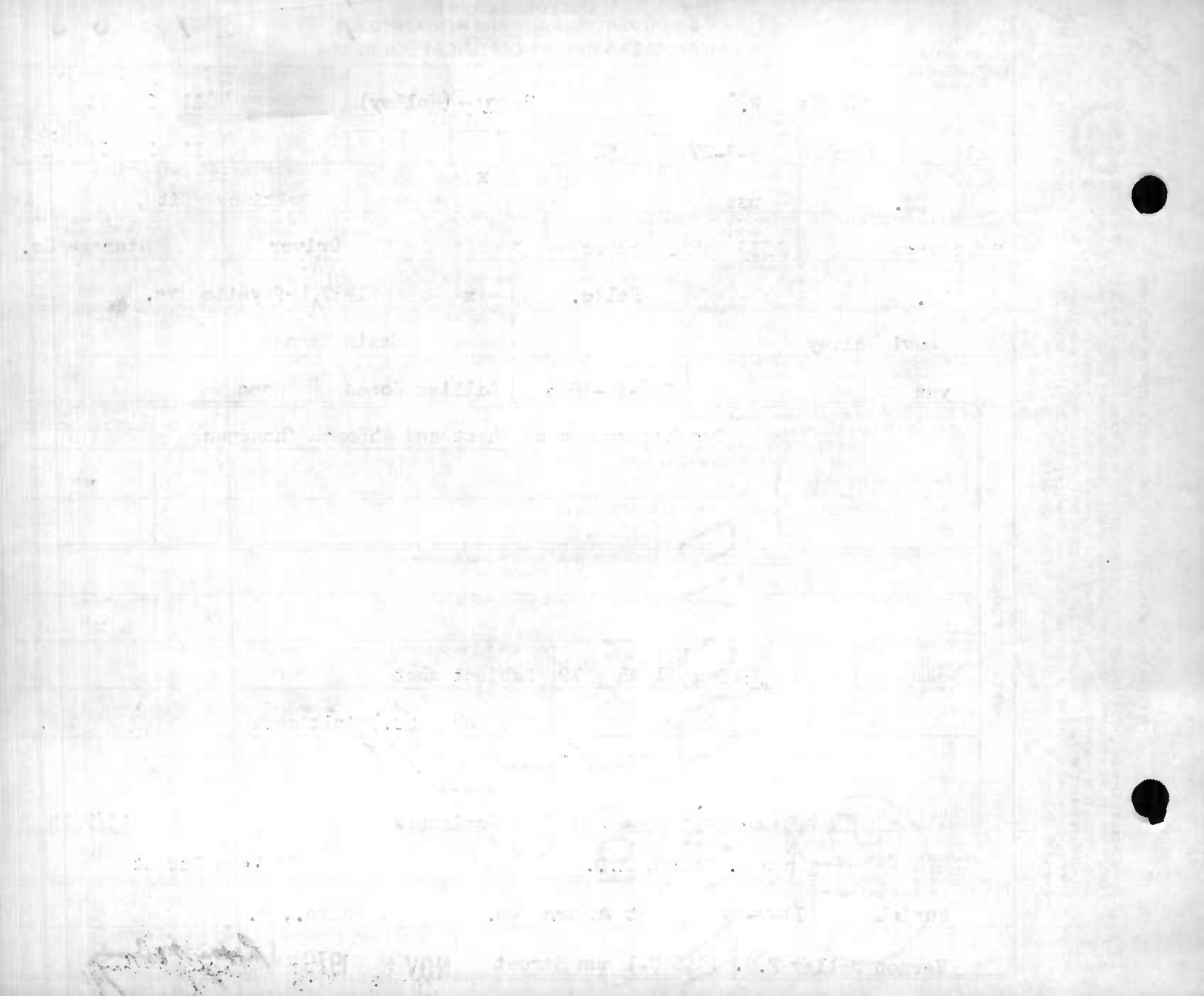




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PMA 3, RETAIN PAGE 5 FOR THE MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

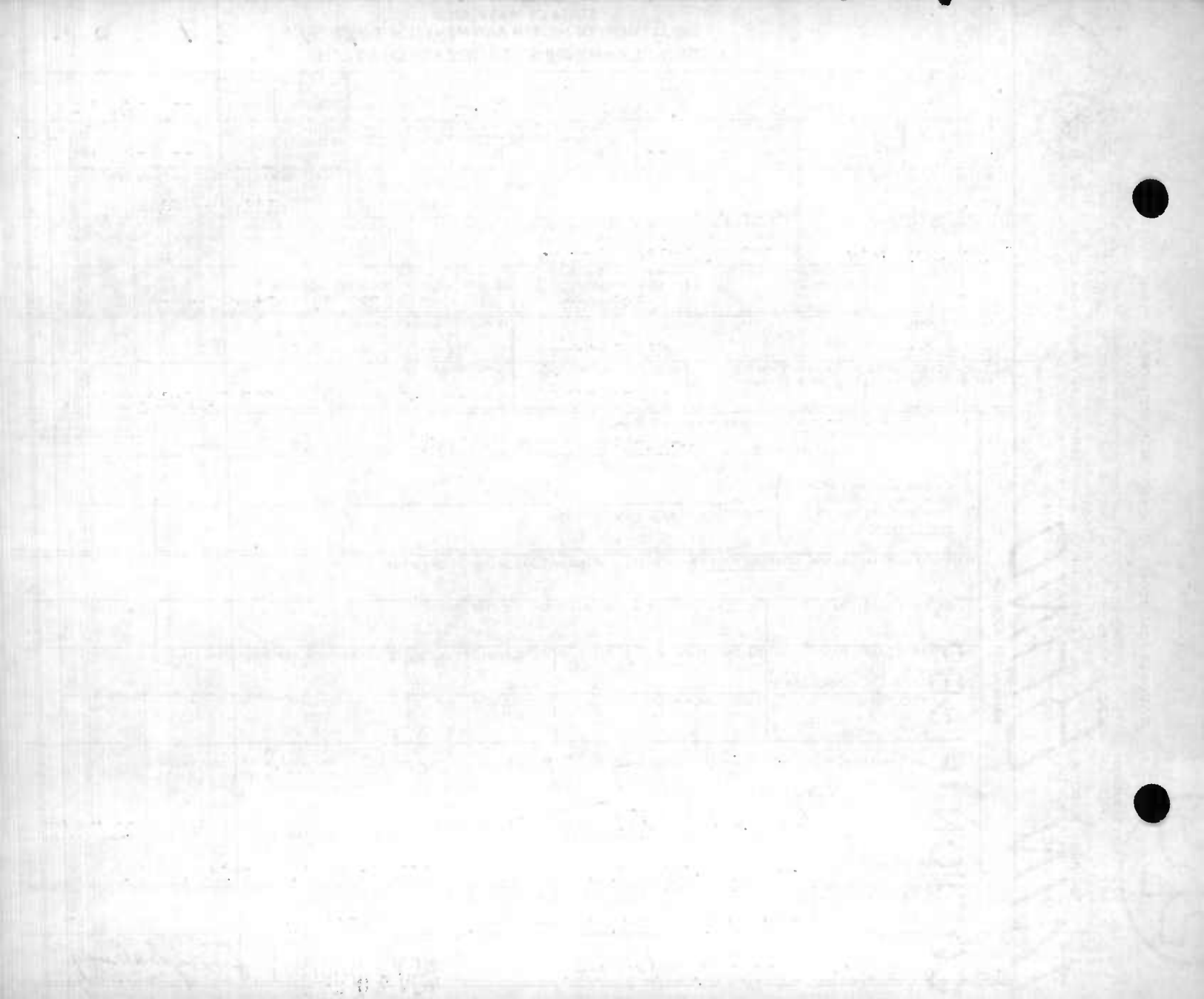
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | REG. NO. 27463  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Louis F. Holley (Holley)</b>   |  |   |  |  |  | 2a. DATE OF DEATH<br>KNOWN ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 3 1979</b> |  | 7b. HOUR<br><b>5:45 A M</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-3-27</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br><b>52</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 3 1979</b>                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>usa</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1518 Baker Street</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Driver</b>                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Storage Co.</b>   |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13a. STATE<br><b>Md.</b>  |  |  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS<br><b>1937 Lafayette Ave.</b>   |  |  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Levi Holley</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mamie Barnes</b>  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-28-1016</b>  |  | 17. INFORMANT<br><b>Lillian Jones</b>  |  | ADDRESS<br><b>same</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wounds of Chest and Abdomen (handgun)</b><br>9650<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5:29 PM 11 3 1979</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot</b> |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>house</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1518 Baker St., Baltimore Md.</b>            |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |  |  |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |  |  | MEDICAL EXAMINER  |  | DATE SIGNED<br><b>11/3/79</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |  |  |  | ADDRESS<br><b>111 Penn Street</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-9-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cem.</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Vernon Bailey F.H. 1348 Calhoun Street</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 8 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO. 27464   |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Ada J. Holmes |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11 16 79   |  | 2b. HOUR<br>M 3:03A  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 18 12   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                    |  | 7. IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>11 16 79                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>322 N. Fulton Avenue |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>322 N. Fulton Avenue                                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Shepherd Singletary   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Lee  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>217-16-3315   |  | 17. INFORMANT<br>Mary Walker  |  | ADDRESS<br>322 N. Fulton Ave.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive heart failure<br>4280<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith  |  |   |  | TITLE (SPECIFY)<br>M.D. Deputy Chief  |  |   |  | DATE SIGNED<br>11/20/79  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |   |  | ADDRESS<br>111 Penn St. Balto., MD.   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>11/20/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore MD  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm C March F/H  |  |   |  | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1979                                  |  | 25b. REGISTRAR'S SIGNATURE<br>F. J. McElroy  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |  |   | 7 9 2 7 4 6 5  |   |
|---|---|--|---|--|---|
| 1. FOR<br>STATE<br>REGISTRAR  |   |  |   | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |  | 2a. DATE OF DEATH                           |  |   |
| FIRST MIDDLE LAST<br><b>WILLIAM EDWARD HOLMES</b>   |   |  | MONTH DAY YEAR<br><b>11 13 79</b>           |  | 2b. HOUR<br><b>1:04A M</b>  |
| 3 SEX   | 4 RACE  | 5. DATE OF BIRTH   | 6 AGE (IN YEARS LAST BIRTHDAY)              |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                      |
| <b>MALE</b>   | <b>WHITE</b>  | MONTH DAY YEAR<br><b>9 - 17 - 1895</b>                                 | <b>84 74</b> YRS.                           |  | IF UNDER 24 HRS<br>HOURS MIN.                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |   |  |   |
| <b>MARYLAND</b>   | <b>U.S.A.</b>   | <b>BALTIMORE, CITY</b> MD.   |   |  |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| <b>BALTIMORE</b>  | <b>VAMC, LOCH RAVEN</b>   | <b>Buyer</b>   |   | <b>Wholesale Market</b>  |   |
| 13a. STATE  |   |  | 13b. COUNTY                                 | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |
| <b>MARYLAND</b>   |   |  | <b>Baltimore</b>                            | <b>Arbutus</b>   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME   |   |  | 15. MOTHER'S MAIDEN NAME                    |  |   |
| FIRST MIDDLE LAST<br><b>Oliver W. Holmes</b>  |   |  | FIRST MIDDLE LAST<br><b>Clara W. Straut</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |   |
| <b>Yes</b>  |   | <b>WWI</b>   |   | <b>21227 Mrs Evelyn M. Carnes 1316 Birch Ave.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>586-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEPTIC SHOCK</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b><br><b>6 days</b><br><b>7 days</b> |   |  |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>RENAL FAILURE / HEPATIC FAILURE</b>   |   |  |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?  |   |
| <b>NA</b>   |   | <b>NA</b>  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>PM 19</b>        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>3900 LOCH RAVEN BLVD., BALTO. MD. 21218</b> |   |
| 22a. I certify that (this hospital) attended the deceased from <b>11-4</b> , 19 <b>79</b> , to <b>11-13</b> , 19 <b>79</b> , that (we) lost<br>saw the deceased alive on <b>11-13</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above (or we) did not view the body after death.   |   |  |   |  |   |
| 22b. SIGNATURE<br><b>Daniel J. W. Rando</b>   |   |  |   | 22c. DATE SIGNED<br><b>11/13/79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. Rando W</b>  |   |  |   | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Balto. Md.</b>                                      |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   |
| <b>Burial</b>   |   | <b>11/16/1979</b>  |   | <b>Lorraine Park</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME  |   | ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR  |   |
| <b>G. Truman Schwab</b>   |   | <b>3512 Frederick Ave.</b>   |   | <b>21229</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Kelly</b>  |   | 25c. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1979</b>                    |   |  |   |



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |   |  |  |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Blanche</i>  |  | FIRST<br><i>V.</i>  |  | LAST<br><i>Holy</i>  |  | 2a. DATE OF DEATH<br>MONTH<br><i>11</i> DAY<br><i>5</i> YEAR<br><i>79</i>            |  | 2b. HOUR<br><i>1:15</i> A.M.  |  |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Caucasian</i>   |  | 5. DATE OF BIRTH<br>MONTH<br><i>5</i> DAY<br><i>3</i> YEAR<br><i>1927</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>52</i> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS<br><i></i> DAYS<br><i></i>   |  | 8. IF UNDER 24 HRS<br>HOURS<br><i></i> MIN.<br><i></i> |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>South Baltimore Geriatric</i> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Custodian</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>A.A. CO</i><br>DEPT. OF ED.   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>  |  |   |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br><i>529 Freeman St.</i>          |  |
| 14. FATHER'S NAME<br>FIRST<br><i>(Nicholas)</i> MIDDLE<br><i>William</i> LAST<br><i>Smith</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>Mary</i> MIDDLE<br><i>Schmidt</i> LAST<br><i>Schmidt</i>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>219222574</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Mr. G. Joseph Holy same as 13 e</i>   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i><br><i>4292</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>CVA</i><br>(c) <i>ASVD, Pulmonary vascular insufficiency</i>              |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>Diabetes Mellitus</i>   |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>11/1/79</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>1st Carotid Artery Stenosis</i>  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/28</i> 19 <i>79</i> to <i>11/5</i> 19 <i>79</i> , that (I) (we) lost<br>saw the deceased alive on <i>10/5</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><i>James M. Watson</i>   |  |   |  | DEGREE   |  |  |  | 22b. DATE SIGNED<br><i>11/6/79</i>  |  |  |  |
| 22c. PHYSICIAN'S TYPE OR PRINT<br><i>WATSON KIME</i>   |  |   |  | 22e. ADDRESS<br><i>3001 S. HANOVER ST. BALT. 21225</i>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>11/9/79</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Glen Haven Mem Pk</i>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Glen Burnie A.A. Md.</i>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>George J. Gonce</i> ADDRESS<br><i>4001 Ritchie Hwy</i>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 09 1979</i>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Henry McCreedy</i>   |  |  |  |





X

X

X

*Revised*

WATSON KIRK

11/10/77

11/10/77

NOV 10 1977

George J. Gorce 4001 Nichols Ave



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9   |  | 2 7 4 6 7   |  | REG. NO.  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| ARTHUR   |  | HORTON  |  |   |  |   |  | 11-06-79   |  | 8:25pm                                       |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. UNDER 24 HRS<br>HOURS MIN                 |  |
| Male   |  | Negro   |  | 12 21 1894  |  | 84  |  | YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |
| North Carolina   |  | U. S. A.  |  |   |  | Baltimore MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore  |  | Church Home Hospital  |  |   |  |   |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |  |  |
| Maryland   |  |   |  | Baltimore   |  |   |  | 271 Mason Court  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |   |  |  |  |  |  |
| Bryan  |  | Horton  |  | Polly   |  | Lee   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |  |  |
| No   |  | 216-30-9371   |  | Maefield Horton   |  | 1329 East Valley Street   |  |  |  |  |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br><u>5939</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>MALNUTRITION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>RENAL INSUFFICIENCY</u> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-01-</u> 19 <u>79</u> , to <u>11-06-</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-06-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>K. S. Shenoy</u>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><u>Nov. 6. 79</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DR. K. S. SHENOY</u>   |  | 22e. ADDRESS<br><u>CHURCH HOSPITAL CORPORATION</u><br><u>100 N. BROADWAY BALTIMORE, MARYLAND 31</u>       |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>11/12/1979</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mount Calvary Cem.</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Maryland</u>                        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |  |  |
| <u>Wm. C. March F/H 1101 East North Avenue</u>   |  | <u>NOV 9 1979</u>   |  | <u>[Signature]</u>  |  |   |  |  |  |  |  |

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FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                        |  |  |   |                            |
|--|------------------------|--|--|---|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ethel L. Horton</b>   |                        |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>14</b> YEAR <b>1979</b>  |   | 2b. HOUR<br><b>8:20 AM</b> |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>25</b> YEAR <b>1893</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.   |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                            |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>House In The Pines</b> |   |                            |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                            |
| 13a. STATE<br><b>md.</b>   |                        |  | 13b. COUNTY  |   |                            |
| 13c. CITY OR TOWN<br><b>Balto.</b>   |                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |                            |
| 13e. STREET ADDRESS<br><b>1005 Lenton Avenue</b>   |                        |  | 14. FATHER'S NAME<br>FIRST <b>Robert</b> MIDDLE <b>T.</b> LAST <b>Cheatham</b>   |   |                            |
| 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lucy</b> MIDDLE <b>Clay</b> LAST  |                        |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |                            |
| 16b. SOCIAL SECURITY NO.<br><b>215-34-6704A</b>  |                        |  | 17. INFORMANT<br><b>FENTON HORTON, SR.</b>   |   |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4409 Arteriosclerosis</b><br>IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                        |  |  |   |                            |
| 19a. DATE OF OPERATION   |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |                            |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>11/11</b> 19 <b>78</b> , to <b>11/14</b> 19 <b>79</b> , that (I) (the hospital) last saw the deceased alive on <b>11/13</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.             |                        |  |  |   |                            |
| 22b. SIGNATURE<br><b>D. Sunshine</b> M.D.<br>DEGREE  |                        |  |  | 22c. DATE SIGNED<br><b>11/14/79</b>   |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>1-SUNSHINE</b>   |                        |  |  | 22e. ADDRESS<br><b>6210 PK. Hg Ave, Balt, Md.</b>   |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                        | 23b. DATE<br><b>11/20/1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn Cemetery</b>  |                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |                        | 24. FUNERAL DIRECTOR<br>NAME <b>MARCH'S Funeral Home</b> ADDRESS <b>1101 E. North Ave.</b>   |  |   |                            |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1979</b>  |                        |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                            |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Robert T. Gresham  
Clay  
John Waterhouse  
A. S. A.  
1882

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |   |  | REG. NO.   |  |   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR   |  |
| Fred  |  |   |  | November 16 1979   |  |   |  | 5:35A M  |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |  |
| Male  |  | Negro   |  | 1 2 DAY 1908   |  | 71 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |  |
| South Carolina  |  | U. S. A.  |  |  |  | Baltimore City MD   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | Maryland General Hospital   |  |  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. INSIDE CITY LIMITS?   |  | 13b. STREET ADDRESS   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. STREET ADDRESS   |  |  |  |
| Maryland  |  |   |  | Baltimore  |  | 1539 Argyle Avenue  |  |  |  |
| 14 FATHER'S NAME  |  |   |  | 15 MOTHER'S MAIDEN NAME  |  |   |  |  |  |
| FIRST MIDDLE LAST   |  |   |  | FIRST MIDDLE LAST  |  |   |  |  |  |
| Louise Horton   |  |   |  | Minnie   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS  |  |  |  |
| No  |  |   |  | 240-12-4551  |  | Terba Fountain 1539 Argyle Avenue                                   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>586-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Renal Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>October 14</u> , 19 <u>79</u> , to <u>November 16</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>November 16</u> , 19 <u>79</u> , and that in <u>2630</u> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |   |  | DEGREE   |  |   |  | 22c. DATE SIGNED   |  |
| <u>Susan Schwartz</u>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  |   |  | 11-16-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |   |  |  |  |
| Susan Schwartz, M.D.  |  |   |  | c/o Maryland General Hospital  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |
| Burial  |  | 11/21/79  |  | Mount Calvary Cemetery   |  | Baltimore, Maryland   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Wm. C. March F/H 1101 East North Avenue   |  |   |  | NOV 19 1979  |  | <u>History that code</u>  |  |  |  |

November 10 1973

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Baltimore City

Maryland General Hospital

Baltimore

Pneumonia

General Hospital

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X

November 10 73

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October 10 73

November 10 73

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11-10-73

X

of Maryland General Hospital

Baron Schwabert, M.D.

Nov 10 1973



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  | REG. NO.                              |  |
|---|--|--|---|--|---------------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  | 7 9 27 470  |  |                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR                              |  |
| CHARLES L. HOUCK JR.  |  |  | 11 29 79  |  | 10:40 A                               |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. UNDER 1 YEAR                       |  |
| MALE  | WHITE  | 09 23 09   | 70 YRS  |  | MONTHS DAYS HOURS MIN                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                       |  |
| MARYLAND  | U.S.A.   |  |   | BALTIMORE CITY MD.   |                                       |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY     |  |
| BALTIMORE   | ST. AGNES HOSPITAL   |  | PRESS OPERATOR  |  |                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS                   |  |
| 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN ARBUTUS   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 21229 1021 MAIDEN CHOICE LANE, APT. 1 |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                       |  |
| CHARLES L. HOUCK SR.  |  |  | GENEVIEVE BAER  |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                       |  |
| NO  |  | 215-03-0574  |   | THELMA V. HOUCK, 1021 MAIDEN CHOICE LANE   |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |                                       |  |
| IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u>  |  |  |   |  |                                       |  |
| 410- DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |                                       |  |
| (b) <u>Myocardial Infarction</u>  |  |  |   |  |                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |                                       |  |
| (c) <u>Previous MI's, D.M., CVA</u>   |  |  |   |  |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |                                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                       |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |   |  |                                       |  |
|   |  | P.M. 19  |   |  |                                       |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |                                       |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   | STREET CITY OR TOWN COUNTY STATE   |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 29</u> 19 <u>79</u> to <u>Nov 29</u> 19 <u>79</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                       |  |
| 22b. SIGNATURE <u>E. Myers</u>  |  |  |   | DEGREE   |                                       | 22c. DATE SIGNED   |
|   |  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                       | <u>Nov 29/79</u>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   | 22e. ADDRESS   |                                       |  |
| E. MYERS, M.D.  |  |  |   | 900 CATON AVE. BALTIMORE, MD. 21229  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                       | 23d. LOCATION  |
| BURIAL  |  | 12-01-79   |   | NEW CATHEDRAL  |                                       | CITY OR TOWN COUNTY STATE                                      |
|   |  |  |   |  |                                       | BALTIMORE CITY MARYLAND  |
| 24. FUNERAL DIRECTOR  |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |                                       | 25b. REGISTRAR'S SIGNATURE                                     |
| NAME ADDRESS  |  |  |   | 21229  |                                       |  |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.  |  |  |   | NOV 30 1979  |                                       |  |



BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*

200 CATON AVE. BALTIMORE, MD. 21205

H. W. W. W.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |  | 7 9 2 7 4 7 1  |  |
|--|---|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |   |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <sup>1</sup> ALFONSO (ALFOUNSA) <sup>2</sup> W. HOUSE  |   |   | 2a. DATE OF DEATH  |  | 2b. HOUR                                     |
|  |   |   | MONTH DAY YEAR   |  | 10:15 AM                                     |
| 3 SEX<br>MALE  | 4 RACE<br>BLACK   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
|  |   | MONTH DAY YEAR  |  | 58   |  |
|  |   |   |  | YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SOUTH CAROLINA  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VETERANS ADMINISTRATION MEDICAL CENTER |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>MARYLAND   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES HOUSE  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LOUISE WATSON   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |   |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>WW 2   |  |  |
| 17. INFORMANT  |   |   | ADDRESS  |  |  |
| VAMC, Clinical Records Baltimore, Md. 21218  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ADENOCARCINOMA OF LUNG &amp; BRAIN METASTASES</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 11, 1979</u> to <u>NOVEMBER 10, 1979</u> that (I) (we) last saw the deceased alive on <u>NOVEMBER 10, 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Raymond Flores MD</u>   |   |   |  | 22c. DATE SIGNED<br><u>11/10/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAYMOND FLORES MD   |   |   |  | 22e. ADDRESS<br>3900 LOCH RAVEN BLVD. BALTO., MD. 21218  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>1-16-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. National Cem  |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore   |   | 23e. COUNTY<br>Maryland   |  | 23f. STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Isaiah L. Brown & Son PA 1913 W. Balto. St.  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1979                     |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Isaiah L. Brown</u>   |   |   |  |  |  |

10:15 PM 11/10/50

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

URGENT 11/10/50

[illegible text block]

NOVEMBER 10, 1950

3000 [illegible] [illegible]

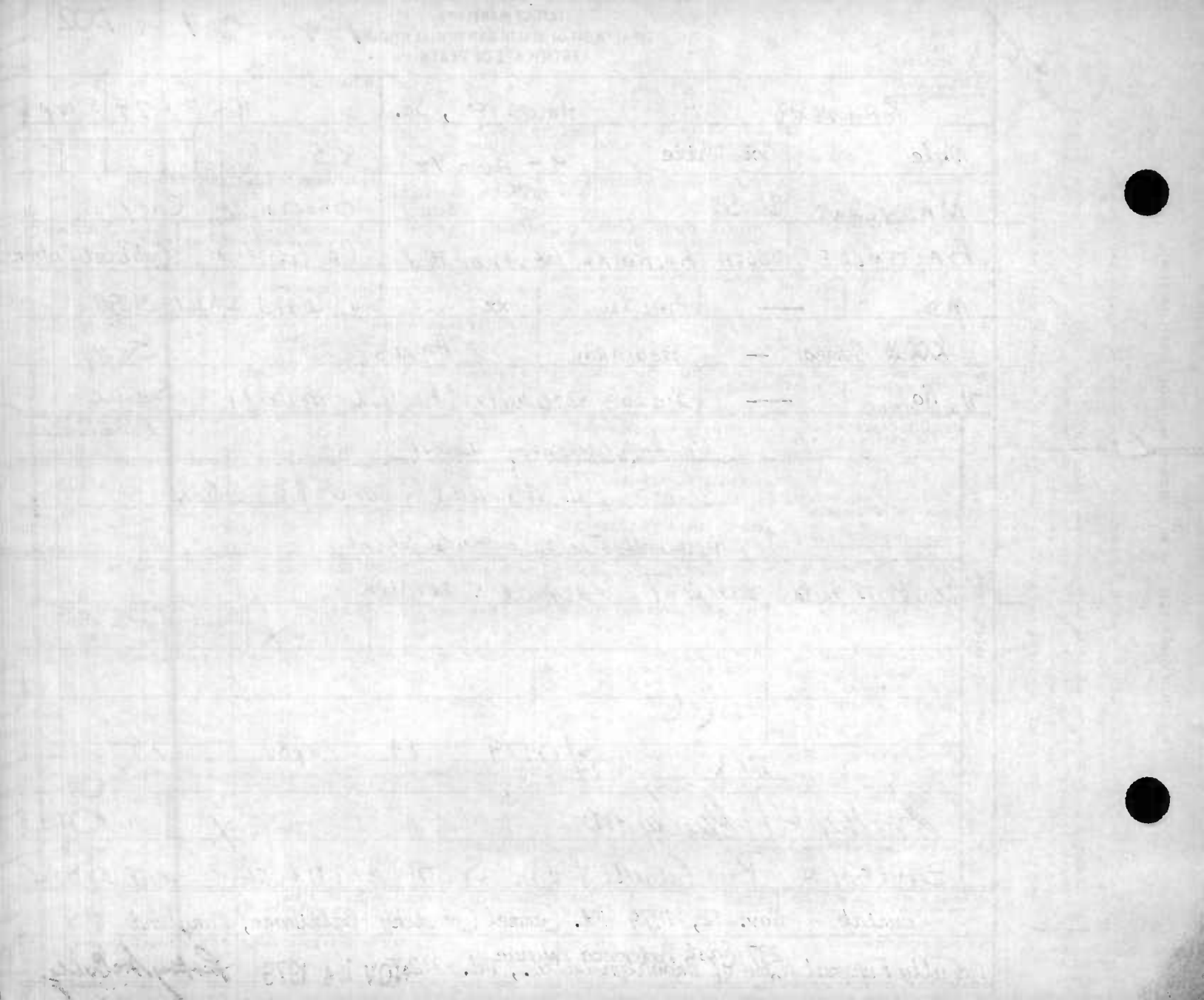
NOV 11 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 7 9 27472   |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>RAYMOND   |  | MIDDLE<br>A.  |  | LAST<br>Howard, Sr.  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-8-79   |  | 2b. HOUR<br>5:10 P M                                 |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9-30-96   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN                         |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL HOSP. |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>(Retired)  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>(Cabinet Maker) |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |  |  |  |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1140 Ward Street 21230  |  |  |  |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)<br>James  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)<br>Agnes Sapp   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---   |  | 17. INFORMANT<br>Wife (Bertrude Howard)   |  |  |  | ADDRESS<br>Same  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Congestive heart failure, COPD, Pneumothorax<br>(c) Arterioarterial cardiovascular disease |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Cerebrovascular accident, Laceration's contusion  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/25/79, 19 79, to 11/8, 19 79, that (I) (we) lost saw the deceased alive on 11/8, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Barbara R. Cowley MD   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11-8-79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BARBARA R. COWLEY MD.   |  |  |  |   |  | 22e. ADDRESS<br>SOUTH BALTIMORE GENERAL HOSP.  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 12, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Carmel Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home of Brooklyn Balto., Md.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>Barbara R. Cowley  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Harley W Howell</b>                      |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 2, 1979</b> |  |  | 2b. HOUR<br><b>4:00pm</b>   |  |   |  |   |  |
| 3 SEX<br><b>M</b>   |  | 4 RACE<br><b>W</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 6 1908</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>71</b>   |  | 8 IF UNDER 24 HRS<br>HOURS MIN.<br><b>4:00pm</b>    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Iowa</b>                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                          |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. executive</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Leasing</b>   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Lutherville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1504 Long Quarter Ct.</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hardy Howell</b>                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Hannah</b>  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>318 05 6395</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Geneva E. Howell Same</b>                              |  |   |  |   |  |

|   |  |  |  |
|---|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b>             |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>15 minutes</b> |  |
| 1509<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Esophageal Cancer</b> |  | 16 months  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>78</b> , to <b>Nov 2</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>November 2 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Frederick E. Munschauer M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11/2/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FREDERICK E. MUNSCHAUER</b>   |  |  |  | 22e. ADDRESS<br><b>601 N. BROADWAY</b>   |  |  |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>11/5/79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |  |
|---|--|-----------------------------|--|---|--|---|--|

|   |  |                                  |  |   |  |  |  |
|---|--|----------------------------------|--|---|--|--|--|
| 24 FUNERAL DIRECTOR<br>NAME<br><b>MITCHELL-WIEDEFELD HOME</b> |  | ADDRESS<br><b>6500 York Road</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 06 1979</b> |  | 25b. REGISTRAR'S SIGNATURE<br><i>John H. Brady</i> |  |
|---|--|----------------------------------|--|---|--|--|--|

The Johns Hopkins Hospital  
 Baltimore, Md.  
 July 1901  
 No. 100

George Washington  
 Long River, Md.

Frederick B. Mendenhall, M.D.  
 U.S. Geol. Surv.  
 Washington, D.C.  
 July 1901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #22a Film 0537 11/26/79 re

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Huckeba, Oscar D. Huckeba</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 / 12 / 79</b> |   |  | 2b. HOUR<br><b>11 30 A.M.</b>   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 / 11 / 16</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b>   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK, INDUSTRY OR SERVICE OF WORKING LIFE)<br><b>Worker</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>MD</b> 13b COUNTY <b>Baltimore</b> 13c CITY OR TOWN <b>Dundalk</b> |  |   |  |   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>7902 Kavanaugh Rd.</b>  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter M. Huckeba</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Hicks</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>259-12-4294</b>   |  | 17. INFORMANT<br><b>Reba Huckeba</b>  |  | ADDRESS<br><b>7902 Kavanaugh Rd<br/>Balto. MD 21222</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary artery disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b><br><b>Unknown</b> |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>None</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>November</b>   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>November</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>November</b>  |  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>12 Nov. 79</b> , to <b>12 Nov. 79</b> , that (b) (we) lost saw the deceased alive on <b>12 Nov. 79</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Robert W. Hand, M.D.</b>   |  |   |  | DEGREE<br><b>Attending Physician</b>  |  | 22c. DATE SIGNED<br><b>11/12/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert W. Hand</b>  |  |   |  | 22e. ADDRESS<br><b>22 So. Greene St.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/15/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A., MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1979</b>   |  |   |  |
| 25b. ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>  |  |   |  | 25c. SIGNATURE<br><b>[Signature]</b>  |  |   |  |

BP

DHMH - 16 25M

(VR A 15 (4)) 9/74

MADE IN U.S.A.  
100% COTTON

100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. (Post-mortem may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   | REG. NO.  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mary Rose Hudon</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>13</b> YEAR <b>79</b>                               |   |  | 2b. HOUR<br><b>5-PM</b>   |  |  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>cau.</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>Nov.</b> DAY <b>9</b> YEAR <b>1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. JENKINS MEMORIAL HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1000 S. Caton Ave. Balt; Md. 21229</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto. City</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1000 S. Caton Ave., Balto. Md.</b> |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Carl</b> MIDDLE <b>Yahn</b> LAST <b>Henkle</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Melania</b> MIDDLE <b>Henkle</b> LAST <b>Henkle</b>        |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>              |  |  |  |
| 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT<br>ADDRESS <b>Balto., Md.</b><br><b>Sr. M. Oliver, S.S.N.D., 6401 N. Charles</b>  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 YRS.</b> |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>JULY 9, 1976</b> to <b>NOV 13 1979</b> , that (I) <del>lost</del> saw the deceased alive on <b>NOV 13 1979</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> (did not) view the body after death.                                       |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>John F. Hartman</b>   |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>NOV 13 1979</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN F. HARTMAN</b>  |  | 22e. ADDRESS<br><b>1000 S. CATON AVE. BALTO MD. 21229</b>   |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>   |  | 23b. DATE<br><b>11/17/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Holy Sepulchre</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Rochester</b> COUNTY <b>New York</b> STATE <b>New York</b> |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1979</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Curran Funeral Home</b> ADDRESS <b>Cambridge, Md. 308 High St.</b>   |  | 25a. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>  |   |   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician, it should be detached for use as the burial-transit permit. The funeral director should remove carbon papers 1 and 2 and should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 HUDSON SARAH  
01 30 79

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |                                   |
|---|---|---|--|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>SAMANTHA L HUDSON   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 28, 1979         |  | 2b. HOUR<br>6A M                  |
| 3. SEX<br>FEMALE  | 4. RACE<br>white  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN 30 1979   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>9 28   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |                                   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>md.   |   |   | 13b. COUNTY<br>ANNE ARUNDEL                                      | 13c. CITY OR TOWN<br>ODENTON   |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GARY HUDSON   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JANET PAULTK    |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>NONE   |  | 17. INFORMANT<br>ADDRESS<br>MR GARY HUDSON FATHER Same ast #13   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac failure / hypoxia<br>7456<br>DUE TO, OR AS A CONSEQUENCE OF (b) following repair of A.V. canal defect<br>DUE TO, OR AS A CONSEQUENCE OF (c)                                 |   |   |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>Downs Syndrome  |   |   |  |  |                                   |
| 19a. DATE OF OPERATION<br>11/27/79  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>A.V. canal  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. We did (did not) view the body after death. |   |   |  |  |                                   |
| 22b. SIGNATURE<br>H.V. Schaff   |   | DEGREE  |  | 22c. DATE SIGNED<br>11/28/79   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H.V. Schaff  |   | 22e. ADDRESS  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |   | 23b. DATE<br>11-30-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WEST NEWTON  |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>E. BARNES<br>FLEMING FUNERAL SERVICE  |   | ADDRESS<br>BENSON md  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1979  |                                   |
| 25b. REGISTRAR'S SIGNATURE<br>P. McCreedy   |   | 25c. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WEST NEWTON WESTMORLAND PA.   |  |  |                                   |

BP \_\_\_\_\_



1 UNIT 11  
MAY 11 1964

1100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Gerard Frederick Huesman Sr</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 30, 1979</b>  |  | 2b. HOUR<br>M<br><b>11</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 27, 1912</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>67</b>   | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.<br><b>11</b>               |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5307 Plainfield Ave</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Police Chief Sparrows Point</b>  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| 13a. STATE<br><b>Maryland</b>  |   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Francis J Huesman</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude R Timothy</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216-07-0771</b>  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Gertrude Huesman</b>  |  | <b>Same</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 mos.</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1, 1979</b> to <b>Nov. 30, 1979</b> , that (I) (we) lost<br>saw the deceased alive on <b>Nov. 30, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Albert J Himelfarb M. d.</b>  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Dec 1, 1979</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   | 22e. ADDRESS<br><b>2435 W. Belvedere Ave.</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>12/4/79</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1979</b>   |  |   |

25b. REGISTRAR'S SIGNATURE  
*[Signature]*





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9 2 7 4 7 8  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Leo Omer Huesman   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 21 79 |   |  | 2b. HOUR<br>4:45 P M  |  |
| 3. SEX<br>male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 3 1908  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Librarian                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Arbutus  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Peter I. Huesman   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanche HARTWELL   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>NO   |  |   |  |
| 17. INFORMANT<br>ADDRESS<br>JAMES HUESMAN, 9 MONROE FIELD COURT, 21228   |  | 18. SOCIAL SECURITY NO.<br>218-10-6815  |   |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

431-  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/21/79 12 noon to 11/21/79 4:45 pm, that (I) (we) last saw the deceased alive on 11/21/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Noor M. Merchant M.D.   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/21/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NOOR M. MERCHANT M.D.  |  | 22e. ADDRESS<br>900 CATON AVE. BALTIMORE, MD. 21229                    |  |  |  |   |  |

|  |  |                       |  |   |  |   |  |
|--|--|-----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                       |  | 23b. DATE<br>11-26-79 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 26 1979        |  | 25b. REC'D. BY REGISTRAR<br>(Signature)                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

400 CATHY AVE. BALTIMORE, MD. 2122

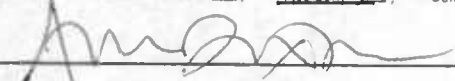
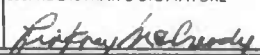
NOV 22 1979

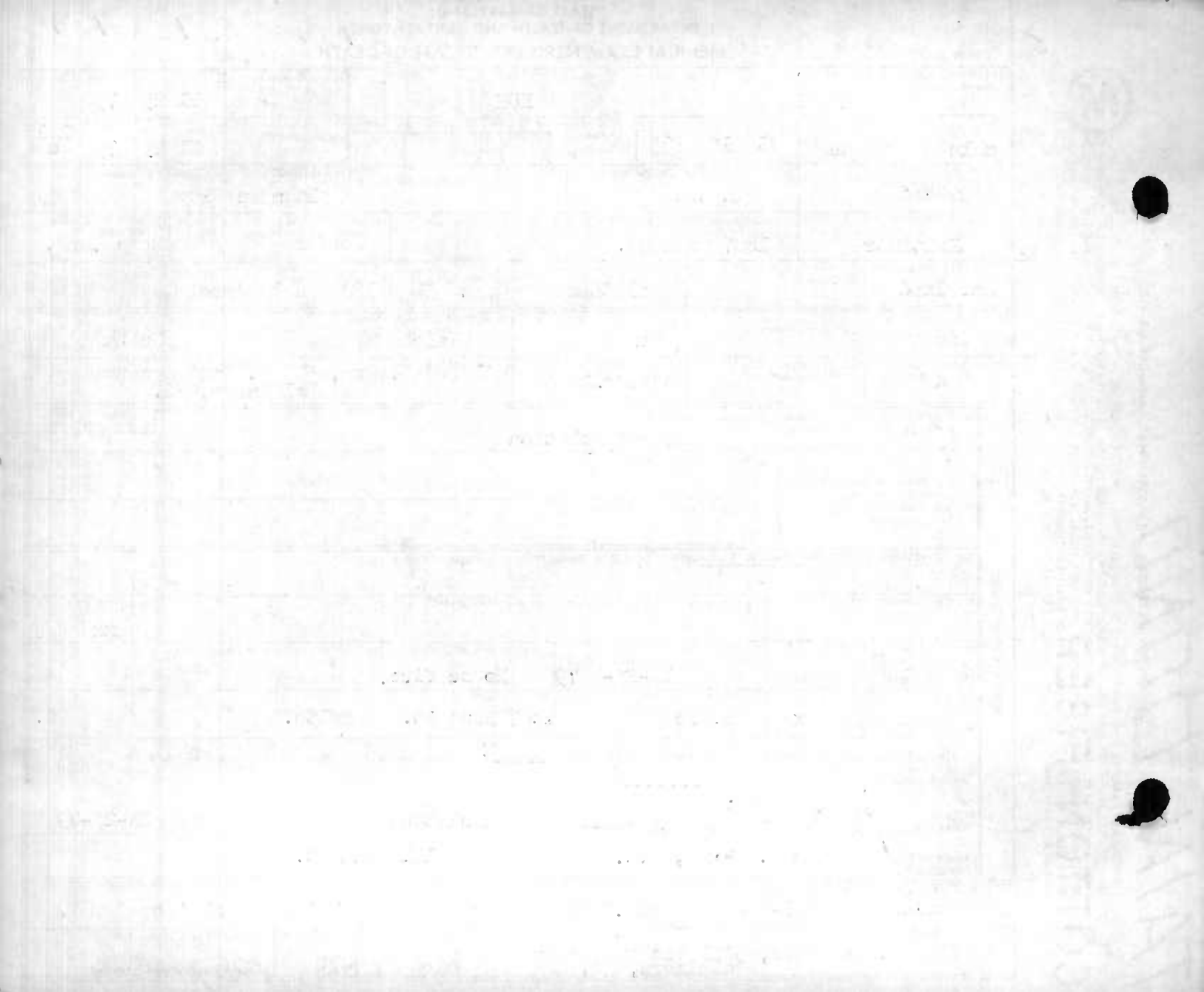


BP  
DHMM - 17  
(VR A15 ME (5))  
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |                             |  |  |  |  |  |  | REG. NO. 27479   |  |
|--|----------------------|--|-----------------------------|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HAROLD HUM</b>  |                      |  |                             |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>25</b> YEAR <b>1979</b> |  |
| 3. SEX <b>male</b>   | 4. RACE <b>white</b> | 5. DATE OF BIRTH <b>11 14 33</b>   | 6. AGE (IN YEARS) <b>46</b> | 7. IF UNDER 1 YR. MONTHS <b>XX</b> DAYS <b>XX</b>  | 8. IF UNDER 24 HRS. HOURS <b>XX</b> MIN. <b>XX</b> | 2c. DATE PRONOUNCED DEAD <b>11 25 79</b>   |  | 2b. HOUR <b>1:15 a</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1807 Bank St.</b> |                             |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roofer</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home Impr.</b>  |  |  |  |
| 13a. STATE <b>Maryland</b>   |                      | 13b. COUNTY  |                             | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 13e. STREET ADDRESS <b>1807 Bank Street</b>  |  |  |  |
| 14. FATHER'S NAME <b>Jacob Hum</b>   |                      |  |                             | 15. MOTHER'S MAIDEN NAME <b>Blanche Hubbard</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                      | 16b. SOCIAL SECURITY NO. <b>214-30-4704</b>  |                             | 16c. ADDRESS <b>Mildred I. Hum, 523 S. East Avenue Baltimore, Md.</b>  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Smoke inhalation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                      |  |                             |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                      |  |                             |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                             |  |  |  |  | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                 |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      | 21b. TIME OF INJURY <b>? P.M. 11-25-19 79</b>  |                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>House fire.</b>   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>   |                             | 21f. LOCATION <b>1807 Bank St. Balto.</b>  |  | CITY OR TOWN <b>Balto.</b>   |  | COUNTY <b>Baltimore</b>  |  | STATE <b>Md.</b>   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .                              |                      |  |                             |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE    |                      |  |                             | TITLE (SPECIFY) <b>Assistant</b>   |  |  |  | DATE SIGNED <b>11-25-79</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |                      |  |                             | ADDRESS <b>111 Penn St.</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>11-28-79</b>  |                             | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>   |  |  |  | 23d. LOCATION <b>Baltimore Baltimore Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Nicholas T. Matthews, 3025 Eastern Avenue Baltimore, Md.</b>   |                      |  |                             | 25a. DATE REC'D. BY REGISTRAR <b>NOV 67 1979</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |   |  |  |  |   |   |                  |  |
|--|--|--|---|---|--|---|--|--|--|---|---|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><i>Leona</i>  |   | MIDDLE<br><i>LORETTA</i>  | LAST<br><i>Hurwitz</i>   | 2a. DATE OF DEATH   |  | MONTH<br><i>11</i>   | DAY<br><i>13</i>   | YEAR<br><i>79</i>   | 2b. HOUR<br><i>2 30</i><br>M                    |                  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>white</i>  |   | 5. DATE OF BIRTH<br>MONTH<br><i>8</i> DAY<br><i>27</i> YEAR<br><i>1899</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>80</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br><i></i> DAYS<br><i></i>                                 |  | IF UNDER 24 HRS.<br>HOURS<br><i></i> MIN.<br><i></i>  |   |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore city</i> MD.                               |  |  |  |   |   |                  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SINAI HOSP. of Baltimore</i> |   |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>   |   |                  |  |
| 13a. STATE<br><i>MD</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>BALTIMORE</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>APT. B. #21215</i><br><i>3915 Fordleigh Rd</i>             |  |   |   |                  |  |
| 14. FATHER'S NAME<br>FIRST<br><i>HARRIS</i> MIDDLE<br><i></i> LAST<br><i>FISHER</i>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>ESTHER</i> MIDDLE<br><i></i> LAST<br><i>UNKNOWN</i>   |  |   |  |  |  |   |   |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>219-32-0682</i>   |   | 17. INFORMANT<br><i>MR. ALBERT S. HURWITZ</i>   |  |   |  | ADDRESS<br><i>3915 FORDLEIGH RD., APT. B. #21215</i>                                 |  |   |   |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac arrest</i><br><i>514-</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>pulmonary edema.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>  |  |  |   |   |  |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |  |   |  |  |  |   |   |                  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i></i> P.M. <i>19</i> |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |   |   |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |  | 21f. LOCATION<br>STREET<br><i></i>  |  | CITY OR TOWN<br><i></i>  |  | COUNTY<br><i></i>   |   | STATE<br><i></i> |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-26-79</i> 19 <i>79</i> , to <i>11-13</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11-13-</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |  |  |   |   |                  |  |
| 22b. SIGNATURE<br><i>Samy Bobawry</i>  |  |  |   |   |  | DEGREE<br><i>MD</i>   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><i>11/13/79</i>             |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SAMY Bobawry</i>   |  |  |   |   |  | 22e. ADDRESS<br><i>Sinai Hosp. of Baltimore</i>   |  |  |  |   |   |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |  |  | 23b. DATE<br><i>NOV. 15, 1979</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>BETH YEHUDA ANSHE KURLAND</i> |   |  | 23d. LOCATION<br>CITY OR TOWN<br><i>BALTIMORE</i>                                    |  | COUNTY<br><i>MARYLAND</i>   |   | STATE<br><i></i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>SOL LEVINSON &amp; BROS., INC.</i><br>ADDRESS<br><i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 19 1979</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Ruby Maloney</i>                                    |  |   |   |                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the local health department. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

81

*[Handwritten signature]*

0501 1 1008



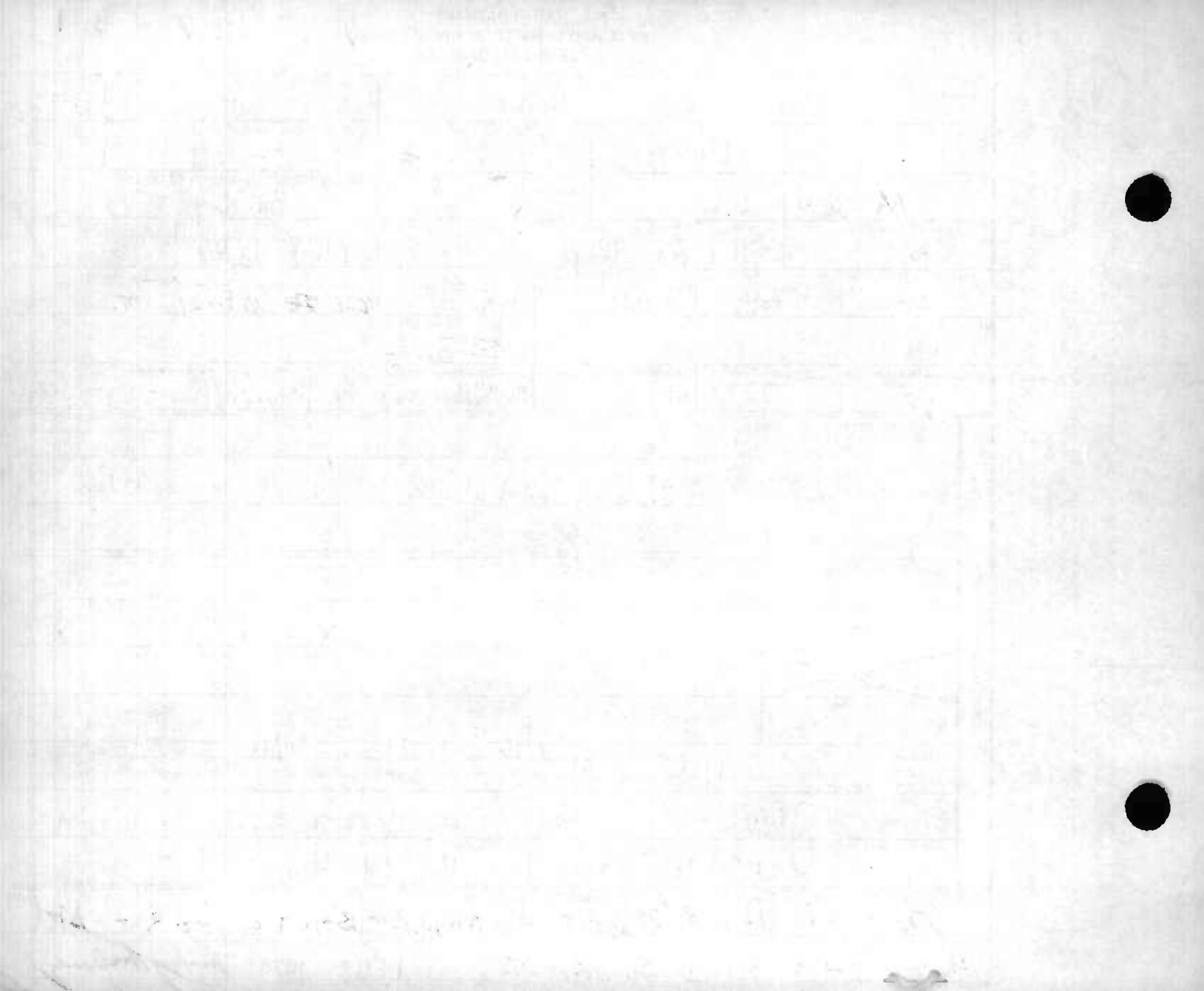
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edna P Hutchins   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 28 79                                       |  | 2b. HOUR<br>1240 P.M.  |
| 3. SEX<br>F  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 1 1926  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City, MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br>Balt.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U-g Md. Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired; disabled |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Balt.  | 13c. CITY OR TOWN<br>Balt.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>N/A  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Betty                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>NA  |   | 17. INFORMANT (Lastname)<br>Ms. Middleton 523-4711 ; Strawberry (i-215-820-3930)     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis.<br>4349<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Massive @ cerebral infarction<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1d.<br>12 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br>-  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |   |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/28/79 to 11/28/79, that (I) (we) lost saw the deceased alive on 11/28/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |   |   |  |  |
| 22b. SIGNATURE<br>J. Oshida MD   |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>11/28/79   |  |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)<br>J. Oshida MD   |  | 22e. ADDRESS<br>U-g Md. Hospital  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Dec 3/79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Md.  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Powell FH 319 N. Schroeder St.  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Kristy McBrady  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the funeral transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

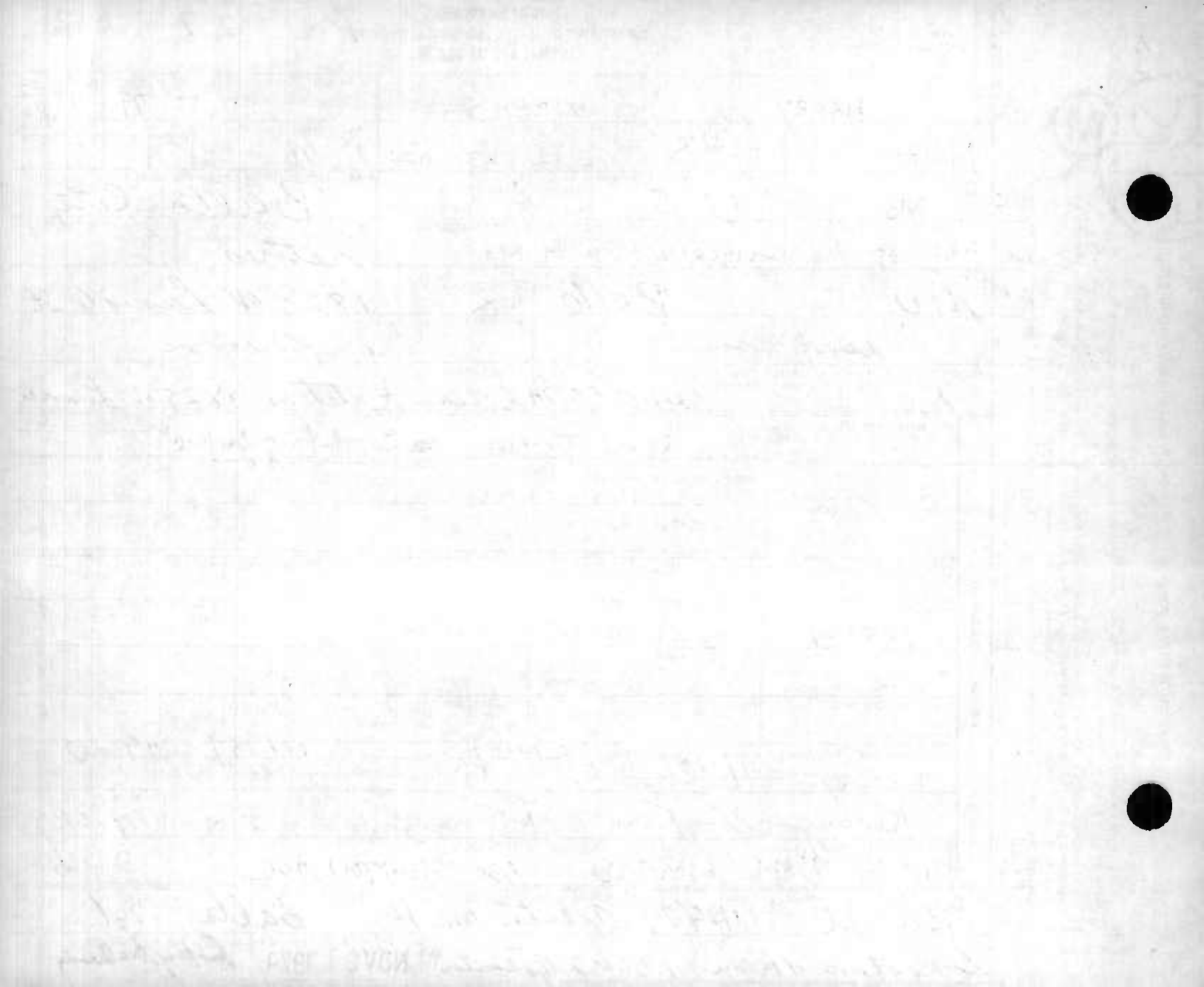
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

35 46 35 300 1 1 9 1

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |                                   |   |  |  |
|--|--|---|--|---|--|--|-----------------------------------|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | REG. NO. 7 9 2 7 4 8 2                                       |  |                                   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HARRY HUTCHINS</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 15 79</b>          |  |                                   | 2b. HOUR <b>12</b> MIN <b>23</b> P M  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 23 02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                  |                                   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City MD.</b>                     |                                   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSP of MD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b> |                                   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>MD</b>  |  |   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTO</b> |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>unknown</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>unknown</b> |  |                                   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-05-55774</b>   |  | 17. INFORMANT ADDRESS<br><b>Lillian Hutchins 1825 W. Lendale St.</b>  |  |  |                                   |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>5370</b> IMMEDIATE CAUSE (a) <b>Renal Failure.</b> <b>Circulatory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |   |  |   |  |  |                                   |   |  |  |
| 19a. DATE OF OPERATION<br><b>10/25/79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gastric outlet obstruction</b>   |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                                   |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10/19/79</b> , 19__ to <b>11/15/79</b> , 19__ that (we) lost <b>saw the deceased alive on 11/15/79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |                                   |   |  |  |
| 22b. SIGNATURE<br><b>Kwang N. Kim</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>11/15/79</b>  |                                   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KWANG NAM KIM, M.D.</b>  |  | 22e. ADDRESS<br><b>730 ASHBURTON AVE 21216</b>  |  |   |  |  |                                   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>11/29/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbuthnot Mem. Pk.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                       |                                   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Locke Funeral Home</b>  |  | ADDRESS<br><b>13042 Arbuton</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony R. Brady</b>                              |                                   |   |  |  |







STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Albert G. Hutzler   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 19, 1979                   |   |  | 2b. HOUR<br>6 A.M.  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 25, 1900   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. City   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>242 S. Monastery Ave. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Fireman                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>504 S. Gilmore St.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jacob L. Hutzler   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie E. Schmidt   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1 1   |  | 17. INFORMANT<br>ADDRESS<br>242 S. Monastery Ave. Balto.<br>Mrs. Katherine E. Hutzler 21229.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Halcyon acute coronary heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>0</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>year</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-4</u> 19 <u>79</u> , to <u>11-19</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-2</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>An</u>  |  |  |  |   | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><u>11-20-79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Truman Schwab</u>  |  |  |  |   | 22e. ADDRESS<br><u>123 VERNE RD. - 8548 B. BALTIMORE</u>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Nov. 21, 1979   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Schwab 5151  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 26 1979   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Truman Schwab</u>       |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STANDARD FORM NO. 64  
MAY 1962 EDITION  
GSA GEN. REG. NO. 27



Handwritten text, possibly a signature or date, oriented vertically in the center of the page.



## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |   |  |  |
|---|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elmer C. Hynson  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 15, 1979 |   |   | 2b. HOUR<br>8:05 PM   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 2, 1919   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1610 Clarkson St. Balto. Md. |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Crane Operator |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>M. Standard |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |   |   |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas ----- Hynson   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Florence ----- Booth   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>10.10.2  |  | 17. INFORMANT<br>ADDRESS<br>Mas. Bertha Hynson, Same as above   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |   |   |   |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |   |  |   |   |   |  |  |
| IMMEDIATE CAUSE (a) RESPIRATORY ARREST  |  |   |  |   |   |   |  |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |   |   |  |  |
| (b) METASTATIC SQUAMOUS CELL CARCINOMA  |  |   |  |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF OF (c) LUNG  |  |   |  |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from 10/2 19 79, to 11/15 19 79, that (we) lost<br>saw the deceased alive on 11/12 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death |  |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br>J. PARBOMENT  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>11/16/79  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. PARBOMENT   |  |   |  | 22e. ADDRESS<br>1211 Wall St. Balto. Md 21230   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 19, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mcully Funeral Home, 130 E. Fort Ave. Balto. Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 16 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

 FOR  
 1 - STATE  
 REGISTRAR

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James C. Iman                                    |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 16, 1979 |   |  | 7b. HOUR<br>M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June, 26, 1920  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Virginia                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Auto Mechanic   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  |   |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry ----- Iman                              |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Evalena ----- Lantz  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>232-26-4286  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Jessie L. Iman, Same as above  |  |   |  |

|  |  |
|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|

 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
 None

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from May 1977, to present 1979, that (I) (we) last saw the deceased alive on Sept 9, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) saw the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Barry F. Weckesser MD<br>DEGREE  |  |  |  |  |  | 22c. DATE SIGNED<br>11/17/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barry F. Weckesser MD   |  |  |  | 22e. ADDRESS<br>301 St Paul Place, Balto. Md.  |  |  |  |

|   |  |                            |  |  |  |   |  |
|---|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                            |  | 23b. DATE<br>Nov. 20, 1979 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lahmansville Cemt. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Grant Co. W. Virginia |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McGully Funeral Home, 130 E. Port Ave. Balto. Md. |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1979             |  | 25b. REGISTRAR'S SIGNATURE<br>Barry F. Weckesser                    |  |

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHINA, TIENTSIN



NOV 18 1912



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>BRIDGET V. IMHOFF</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 9, 1979</b>   |  | 2b HOUR<br><b>12:30 P.M.</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 29 1890</b>                              |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>  |  | 7a CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 7b HOUR<br>MONTHS DAYS HOURS MIN<br><b>YRS</b>                                      |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Home= 1103 Cooks Lane</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |
| 12b KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |  |
| 13a STATE<br><b>Md.</b>  |  | 13b COUNTY<br><b>Balto.</b>   |  | 13c STREET ADDRESS<br><b>1103 Cooks Lane</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JESSE T. DELL</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BRIDGET HICKEY</b>   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b SOCIAL SECURITY NO.<br><b>212-74-7616</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>Joseph Durkin 510 SYLVIE DR. 21122</b>                |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac decompensation due to atherosclerosis</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(a) _____<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b> |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)      |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |
| 22. I certify that (I) (the hospital) attended the deceased from <b>July 10, 1968</b> to <b>November 9, 1979</b> , that (I) (we) lost<br>saw the deceased alive on <b>November 2, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>R. M. McLaughlin, M.D.</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>11/9/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br><b>3708 Mountain Rd. Pikesville, Md 21122</b>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/13/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery Brooklyn A.A. Md.</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |  | ADDRESS<br><b>4001 Ritchie Hwy</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1979</b>                                 |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Harry A. Brady</b>  |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |   |  |   |  |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Rau Frederica Insko</i>                          |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Nov. 20, 1979</i> |   |  | 2b. HOUR<br>A <i>7:30</i> M   |  |   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Oct. 16, 1905</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <i>94</i>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1428 Marshall St. Balto. Md.</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>            |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |   |   |  |   |  |   |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>1428 Marshall St. Balto. Md.</i>      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William ----- Neill</i>                    |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary ----- Hickie</i>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>       |  | 16b. SOCIAL SECURITY NO.<br><i>None</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Marcella Winters, Same as above</i>   |  |   |  |   |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cor. Heart Failure</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCOP</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <i>Dep. Cringing Artillery</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

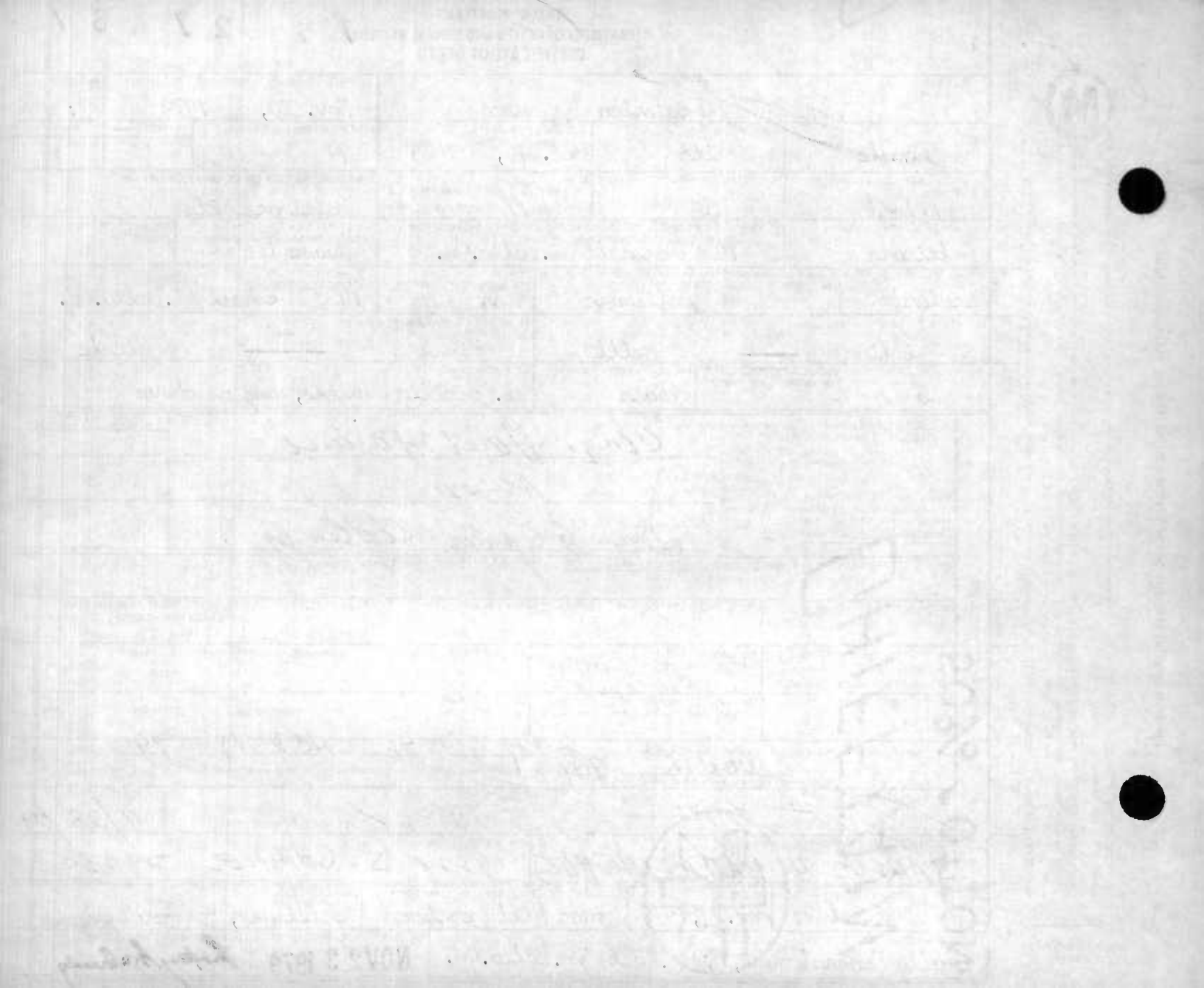
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 18</i> 19 <i>76</i> , to <i>Nov 18</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>Nov 18</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>11/23/79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>CARLOS N. PATALINGHUS</i>  |  |  |  | 22e. ADDRESS<br><i>1228 S. CHARLES</i>   |  |  |  |

|  |  |                                   |  |  |  |   |  |
|--|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                               |  | 23b. DATE<br><i>Nov. 23, 1979</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</i> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 23 1979</i>              |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 5 8557 11/19/79 83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 4 8 8

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MABEL CLAIRE IRVIN   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 5, 1979                       |  | 2b. HOUR<br>M   |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 4, 1898<br><del>1979</del>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Balto.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Balto.  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Hixx  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian McAllister           |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br>William C. Crawford same as 13 e   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Massive heart myocardial infarction</i><br>410 - DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary heart disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerosis</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>25 years |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |
| 22b. SIGNATURE<br><i>Imre Neubauer, M.D.</i>   |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN     |   | 22c. DATE SIGNED<br>Nov 6, 1979  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Imre Neubauer M. D.   |  | 22e. ADDRESS<br>936 Patapsco Ave. Balto. Md.  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>11/8/79   | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Md.                                       |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce 4001 Ritchie Hwy   |  | ADDRESS<br>21225  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 09 1979   |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Patrick McCreedy</i>   |   |  |   |



255. 256.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **7 9 2 7 4 8 9**  
**CERTIFICATE OF DEATH**

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |                             |
|--|---|---|---|--|-----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY A. H. IVES</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 4 28 79</b>  |  | 2b. HOUR<br><b>11:15 AM</b> |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 28, 1918</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                   |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ireland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><input checked="" type="checkbox"/> YES   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |                             |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>                                |                             |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>8203 Bellona Avenue</b>                                    |                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Shaw Hull</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Thomson</b>  |   |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220 48 9580</b>  |   | 17. INFORMANT ADDRESS<br><b>Walter J. Ives Same</b>                                  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the colon</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Anemia, mild renal failure</b>  |   |   |   |  |                             |
| 19a. DATE OF OPERATION<br><b>10/23/79, 11/11/79</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Metastatic carcinoma of colon</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                             |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/28/79</b> , 19 <b>79</b> , to <b>11/28</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/28/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |   |   |   |  |                             |
| 22b. SIGNATURE<br><b>Charles Highstein MD</b>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>11/28/79</b>  |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES HIGHSTEIN, M.D.</b>  |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |   |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11/30/79</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat'l.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Va.</b>                   |                             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>   |   | ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1979</b>                                  |                             |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McQuinn</i>                                 |                             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP \_\_\_\_\_

THE

WASHINGTON CITY

UNION MEMORIAL HOSPITAL

WASHINGTON

UNION MEMORIAL HOSPITAL

WASHINGTON, D.C.

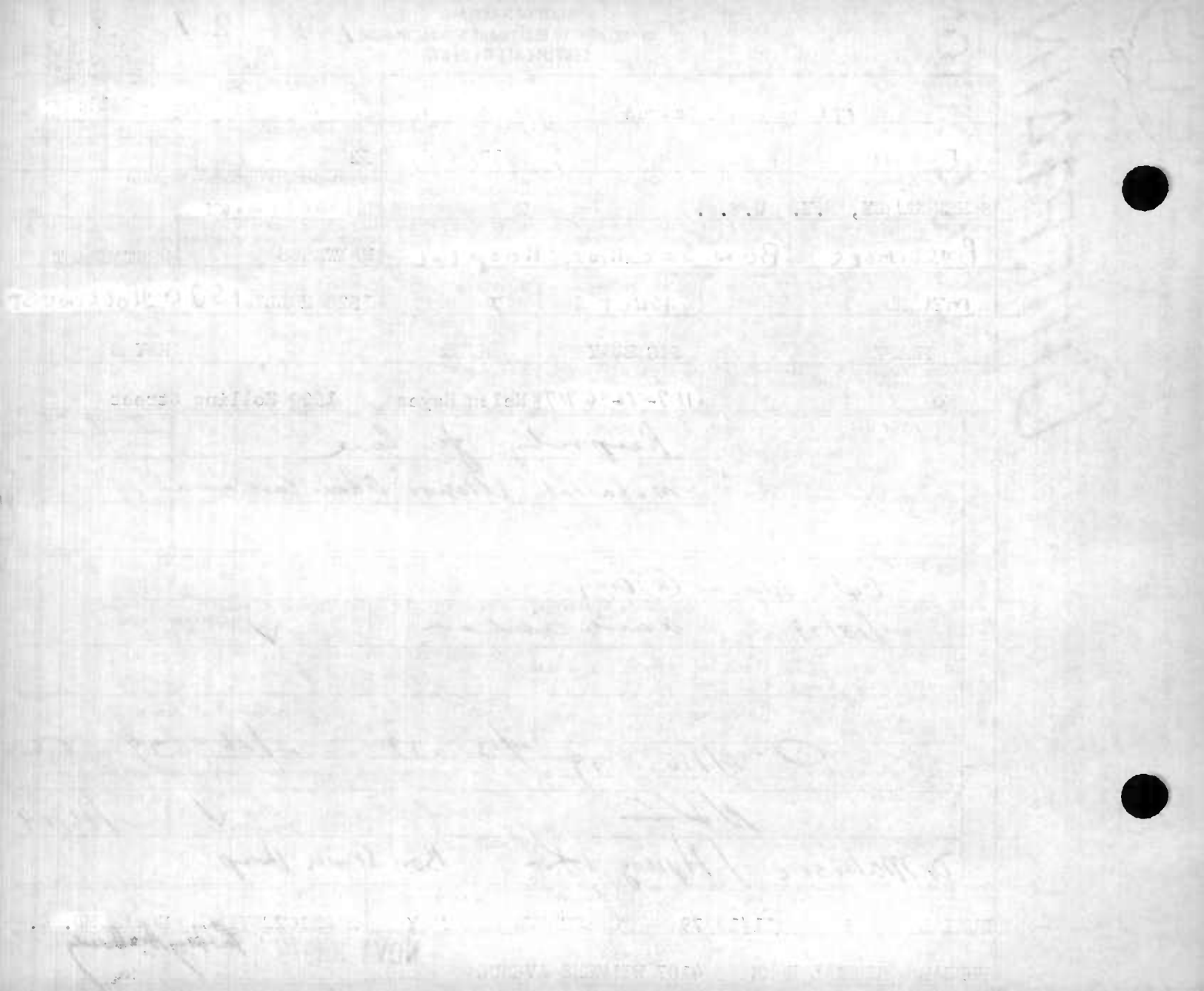
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |                                       |  |   |  |   |  |
|---|--|--|--|---|---------------------------------------|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.   |   |                                       |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Armonde Lauren Jackson</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 16 79</b>              |   | 2b. HOUR<br><b>1:15p M</b>            |  |   |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 17 26</b>   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.                                    |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SCHENECTADY, N.Y.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSPITAL</b> |  |   |                                       | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WAITRESS</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b>   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1520 HOLLINS STREET</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>FRANK SIGSBURY</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>HELEN HAYES</b> |   |                                       |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>117-16-6970</b>                   |   | 17. INFORMANT<br><b>Helen Hayes</b>   |  | ADDRESS<br><b>1520 Hollins Street</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Uterine Adeno. Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |  |  |   |                                       |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Cystic Adenoma (R) Ovary.</b>  |  |  |  |   |                                       |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/13/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Right Adenoma</b>   |  |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/11/79</b> to <b>11/16/79</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/11/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                                       |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Dr. Malaisrie</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                       | 22c. DATE SIGNED<br><b>11/16/79</b>  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Malaisrie</b>   |  | 22e. ADDRESS<br><b>Bon Secours Hosp.</b>   |  |   |                                       |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/19/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CRESTLAWN</b>  |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MARRIOTTSVILLE HOWARD MD.</b>       |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME</b>  |  | ADDRESS<br><b>4107 WILKENS AVENUE</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1979</b>   |                                       | 25b. SIGNATURE OF REGISTRAR<br><b>[Signature]</b>                                    |   |  |   |  |







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 27491

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |  |   |  |  |
|--|--|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ella Mae Jackson  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 14 1979                |  |   | 2b. HOUR<br>5:30pm   |   |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Negro   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 10, 1899   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS   |   | 7 UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Jackson  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lucy Wood              |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   |  |  |
| 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>216-24-2433  |  |   | 17 INFORMANT<br>ADDRESS<br>Avenue William W. Jackson/1417 E. Lafayette |  |   |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): Septic Shock<br>7070<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Infected Decubitus<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 days |  |   |  |  |   |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/12, 1979, to 11/14, 1979, that (I) (we) lost saw the deceased alive on 11/14, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br>Robert Mich MD   |  |   | DEGREE   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>11/14/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Mich   |  |   | 22e. ADDRESS<br>Johns Hopkins Hospital                                 |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>11/19/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus Balto. Md.                                |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>MARSHALL W JONES, JR/4101 EDMONDSON AVE   |  |   | ADDRESS  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1979   |   | 25b. REGISTRAR'S SIGNATURE<br>Fitzroy K. Brady   |  |

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ADJUTANT GENERAL  
U.S. ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 79 27492   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Juanita Jackson C.</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11/14/79</b>   |  | 2b. HOUR <b>3:30 AM</b>   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>05/07/33</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Box Secours</b>                                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13b. STREET ADDRESS <b>2000 West Baltimore St</b>   |  |
| 13a. STATE <b>md</b>  |  | 13b. COUNTY <b>Balto</b>  |  | 14. FATHER'S NAME FIRST MIDDLE LAST <b>James Robinson Jackson</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Harper</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. <b>517-385470</b>  |  | 17. INFORMANT ADDRESS <b>pt Medical Chort</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CA 2 Breast mta</b>  |  |   |  |  |  |   |  |
| 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Widowhood Mother's mta</b>   |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> , 19 <b>79</b> , to <b>11/18</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Helen A. Ph...</b>  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROLAND A. PH...</b>  |  | 22e. ADDRESS <b>111 E. North Ave.</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>11/17/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Bonner Fam. Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Prince George Co., Va.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>H. McQuay</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                         |  |   | 7 9 2 7 4 9 3   |                            |   |  |
|---|-------------------------|--|---|---|----------------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |                         |  |   | REG. NO.  |                            |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Katherine M. Jackson</i>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11-6-79</i> |   | 2b. HOUR<br><i>5:30 PM</i> |   |  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>Black</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 15 15</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>64</i>  |                            | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baer MD</i>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baer City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>John L. Deaton Medical Center</i>    |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Normalton</i>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>at home</i>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>MD</i>   |                         | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 13e. STREET ADDRESS<br><i>1727 N. Beulah</i>  |                         | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>James Young</i>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Clara Burch</i>   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>   |                         | 16b. SOCIAL SECURITY NO.<br><i>no</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Irving Jackson Jr 1727 N Beulah</i>  |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>SEPSIS</i><br><i>1749</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>PNEUMONIA</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>METASTATIC CARCINOMA BREAST</i><br><i>7973</i> |                         |  |   |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 d.</i><br><i>2 d.</i>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                         |  |   |   |                            |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-29</i> , 19 <i>79</i> , to <i>11-6</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11-5</i> , 19 <i>79</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |                         |  |   |   |                            |   |  |
| 22b. SIGNATURE<br><i>Marc Posner M.D.</i>   |                         | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |                            | 22c. DATE SIGNED<br><i>11-6-79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MARC POSNER</i>   |                         | 22e. ADDRESS<br><i>6806 ANNIE RIDGE DR #11</i>   |   |   |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Baer</i>   |                         | 23b. DATE<br><i>11/10/79</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baer Mm PR</i>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baer MD 21227</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>MT Dwyer 6387 G. / NW St</i>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 9 1979</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Ruthy...</i>   |                            |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 4 9 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |                            |  |
|---|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mary E Jackson</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 22, 1979</b> |  | 2b. HOUR<br><b>7:25 am</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Negro</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 18 1930</b>                               |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                      |                            |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                            |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>900 Pennsylvania Avenue</b>  |   |  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel E. Snowden</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Chase</b>   |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><b>219-30-1521</b>   |   | 17. INFORMANT ADDRESS<br><b>Alfred Jackson 900 Pennsylvania Avenue</b>               |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Gastric Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>3y</b>    |  |  |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>none</b>  |  |  |   |  |                            |  |
| 19a. DATE OF OPERATION<br><b>none</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                            |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>11/22</b> , 19 <b>79</b> , to <b>11/22</b> , 19 <b>79</b> , that (1) (we) lost<br>saw the deceased alive on <b>11/22</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. Th (we) (did) (did not) view the body after death. |  |  |   |  |                            |  |
| 22b. SIGNATURE<br><b>Walter L. Bender Jr MD</b>   |  | DEGREE   |   | 22c. DATE SIGNED<br><b>11/22/79</b>  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER L. BENDER JR MD</b>  |  | 22e. ADDRESS<br><b>601 N. Broadway</b>   |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/28/1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Nat. Mem. Park</b>                      |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Maryland</b>   |  |  |   |  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 East North Avenue</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 27 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>D. J. H. H. H.</b>                                  |                            |  |

MEDICAL CERTIFICATION

2  
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1703 BP

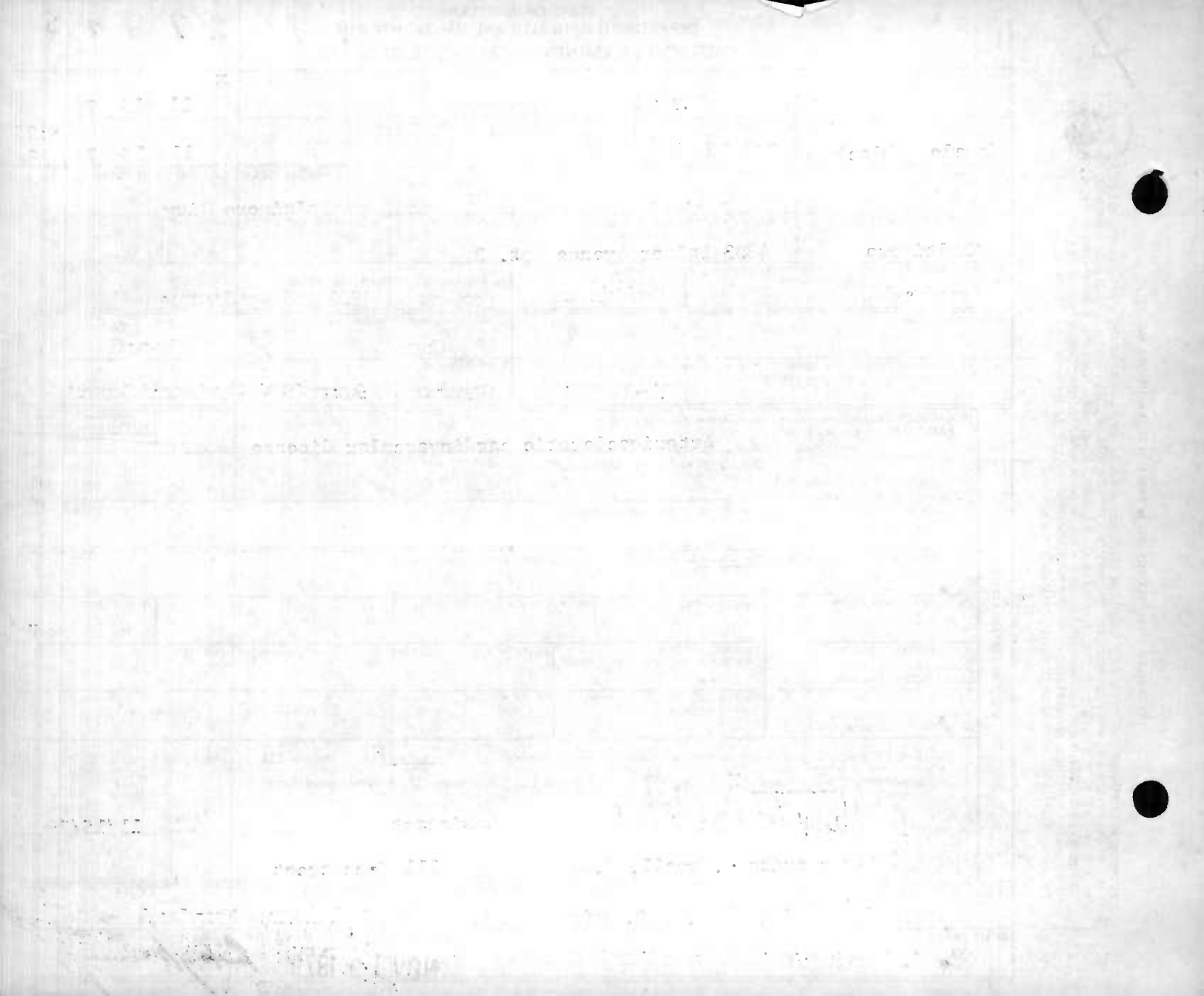




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                   |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                       |  |  |  |  |  |  |  |  |  | REG. NO. 9 27495                     |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--------------------------------------|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR                             |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PEARL Louise JACKSON  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | 11 15 79  |  |  |  |  |  |  |  |  |  | M                                    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH  |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS)                    |  |  |  |  |  |  |  |  |  | 7. IF UNDER 1 YR.     |  |  |  |  |  |  |  |  |  | 8. IF UNDER 24 HRS.                 |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| female  |  |  |  |  |  |  |  |  |  | black   |  |  |  |  |  |  |  |  |  | 3 25 17   |  |  |  |  |  |  |  |  |  | 62 YRS.                              |  |  |  |  |  |  |  |  |  | MONTHS DAYS HOURS MIN |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD            |  |  |  |  |  |  |  |  |  | 2d. HOUR |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |  |  |  |  | 8. MARRIED  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Virginia  |  |  |  |  |  |  |  |  |  | U. S. A.  |  |  |  |  |  |  |  |  |  | WIDOWED XX NEVER MARRIED DIVORCED   |  |  |  |  |  |  |  |  |  | Baltimore City                       |  |  |  |  |  |  |  |  |  | MD.                   |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Baltimore   |  |  |  |  |  |  |  |  |  | 4803 Palmer Avenue Apt. 2   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 13a. STATE  |  |  |  |  |  |  |  |  |  | 13b. COUNTY   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?             |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS   |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | Baltimore   |  |  |  |  |  |  |  |  |  | YES XX NO                            |  |  |  |  |  |  |  |  |  | 4803 Palmer Avenue    |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.             |  |  |  |  |  |  |  |  |  | 17. INFORMANT         |  |  |  |  |  |  |  |  |  | 17. ADDRESS                         |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  | FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  | (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                             |  |  |  |  |  |  |  |  |  | 217-22-2949                          |  |  |  |  |  |  |  |  |  | Cora Howard           |  |  |  |  |  |  |  |  |  | Janette Jackson 3108 Westmont Court |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease               |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 4292  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |  |  |  |  |  |  |  |  | (b)   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | (c)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                         |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | YES NO XX   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  |  |  |  |  |  |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | P.M. 19   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)               |  |  |  |  |  |  |  |  |  | 21f. LOCATION   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| WHILE AT WORK NOT WHILE AT WORK   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | STREET  |  |  |  |  |  |  |  |  |  | CITY OR TOWN COUNTY STATE            |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an   |  |  |  |  |  |  |  |  |  | Autopsy   |  |  |  |  |  |  |  |  |  | Inspection XX   |  |  |  |  |  |  |  |  |  | Inquiry                              |  |  |  |  |  |  |  |  |  | and in my opinion     |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| death resulted from:  |  |  |  |  |  |  |  |  |  | Natural causes XX   |  |  |  |  |  |  |  |  |  | Accident  |  |  |  |  |  |  |  |  |  | Suicide                              |  |  |  |  |  |  |  |  |  | Homicide              |  |  |  |  |  |  |  |  |  | Undetermined manner                 |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY)   |  |  |  |  |  |  |  |  |  | M.D.  |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER                     |  |  |  |  |  |  |  |  |  | DATE SIGNED           |  |  |  |  |  |  |  |  |  | 11/15/79                            |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | Margarita A. Korell, M.D.   |  |  |  |  |  |  |  |  |  | ADDRESS   |  |  |  |  |  |  |  |  |  | 111 Penn Street                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |  |  |  |  |  |  | 23b. DATE   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  |  |  |  |  | 23d. LOCATION                        |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | 11/20/1979  |  |  |  |  |  |  |  |  |  | Mt. Auburn Cemetery   |  |  |  |  |  |  |  |  |  | Baltimore, Maryland                  |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| NAME  |  |  |  |  |  |  |  |  |  | Wm. C. March F/H 1101 East North Avenue                                   |  |  |  |  |  |  |  |  |  | NOV 19 1979   |  |  |  |  |  |  |  |  |  | History & Memory                     |  |  |  |  |  |  |  |  |  |                       |  |  |  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |



Items 18b, Pt. 2, 21a, 21d, e, f G539 STATE OF MARYLAND  
FOR 1/18/80 dad DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
1- STATE REGISTRAR CERTIFICATE OF DEATH

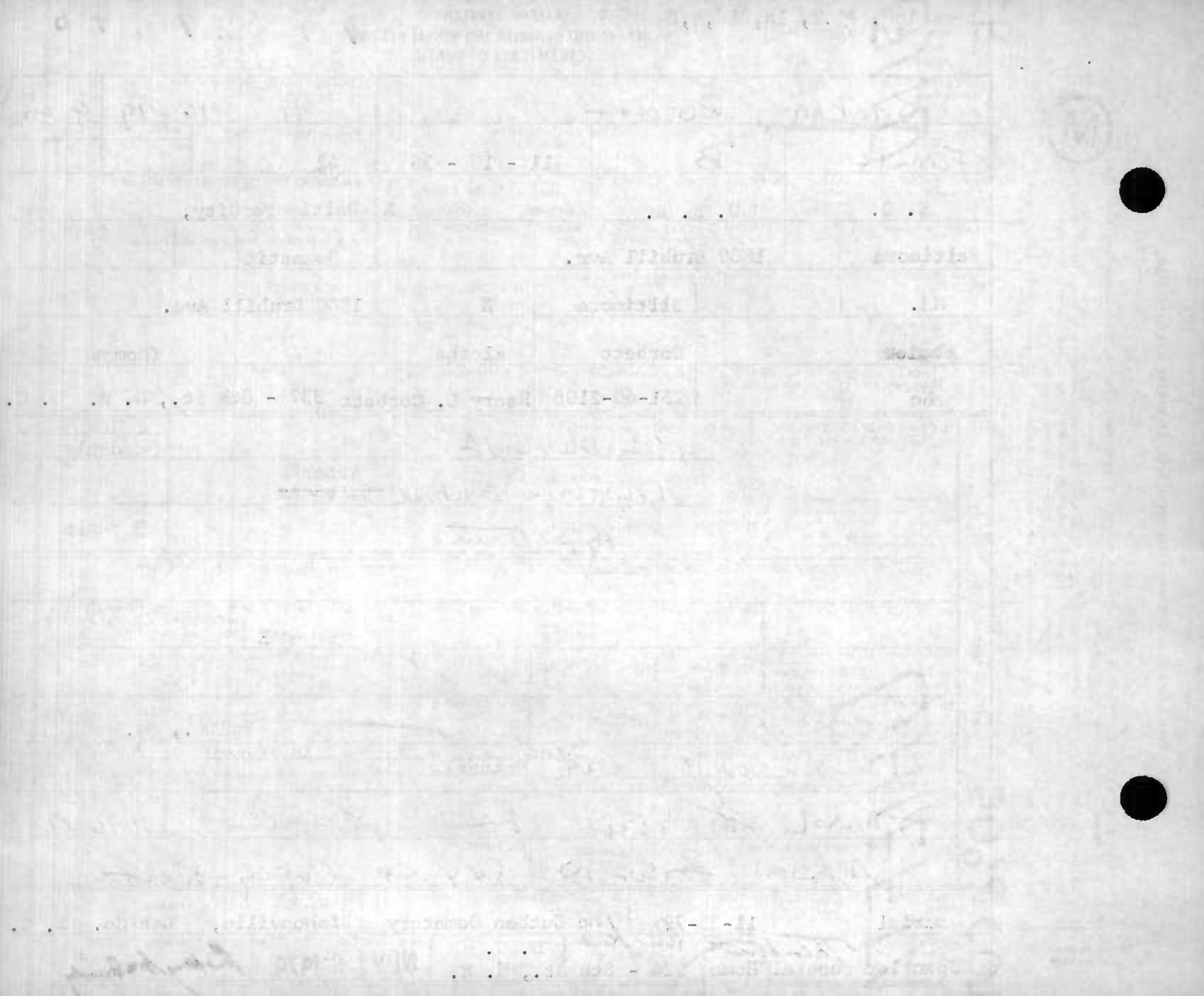
REG. NO. 7 9 2 7 4 9 6

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><u>Jackson, Rosetta</u>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>11 16 79</u>                   |   | 2b. HOUR<br><u>9 AM</u>  |
| 3. SEX<br><u>Female</u>  | 4. RACE<br><u>B</u>                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>11 - 18 - 36</u>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>42</u> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>S. C.</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City, MD.</u>                              |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>1800 Druhill Ave.</u>                       |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Domestic</u>             |  |
| 13a. STATE<br><u>Md.</u>   |   | 13b. COUNTY<br><u>Baltimore</u>   | 13c. CITY OR TOWN<br><u>Baltimore</u>                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><u>1800 Druhill Ave.</u>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Abraham Corbett</u>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Elatha Thomas</u> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>  |   | 16b. SOCIAL SECURITY NO.<br><u>251-60-2108</u>  |   | 17. INFORMANT ADDRESS<br><u>Henry L. Corbett 337 - 8th St., N. E. D. C.</u>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><u>431 -</u> IMMEDIATE CAUSE (a) <u>Populi CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ruptured cerebral artery</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <u>hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Suddenly</u><br><u>3 years</u> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>Home</u>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>Balto., Md.</u>                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 19 79</u> , to <u>November 8, 19 79</u> , that (I) (we) lost<br>saw the deceased alive on <u>Nov. 13 19 79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 23a. SIGNATURE<br><u>Marsha Brown</u>  |   |   |   | 23b. DATE SIGNED<br><u>11-16-79</u>   |  |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Marsha Brown MD</u>  |   |   |   | 23d. ADDRESS<br><u>844 N. Carey Street</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |   | 23b. DATE<br><u>11-23-79</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mc Cuthen Cemetery</u>                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Bishopville, Lee Co. S. C.</u>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Theodore E. McKinney D. C.</u><br><u>Spangler Funeral Home 524 - 8th St., N. E.</u>                              |   | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 19 1979</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Robert H. H. H.</u>   |   |   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 7 9 27 4 9 7  |  |
|---|--|---|--|---|--|
| FOR<br>1 - STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |
| REG. NO.  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LEROY W. JACOBS</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 3 1979</b>  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 7 32</b>  |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>47</b> YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>(USA) Md.</b>  |  | 8. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  | 10. CITY OR TOWN OF DEATH<br><b>Balto. City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hosp</b>            |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>St. of Md.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Traffic Ct.</b>   |  | 13. STREET ADDRESS<br><b>5621 Frankford Ave.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Arthur FRANCIS</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Estelle (Weston) Winston</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes AIR FORCE</b>                            |  |
| 17. INFORMANT ADDRESS<br><b>MAXINE JACOBS 15 N. ELLAMONT</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Ca of lung</b><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET  |  | 21g. CITY OR TOWN   |  | 21h. COUNTY   |  |
| 21i. STATE  |  | 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                      |  |   |  |
| 22b. SIGNATURE<br><b>Prasad A. Dragavarapu</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PRASAD A. DRAGAVARAPU</b>   |  | 22e. ADDRESS  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/9/1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat. Cemetery</b>   |  |
| 23d. LOCATION CITY OR TOWN<br><b>Baltimore Co., Maryland</b>  |  | 23e. COUNTY   |  | 23f. STATE  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March</b>  |  | ADDRESS<br><b>F/H 1101 East North Avenue</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 6 1979</b>   |  |
| 25a. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |   |  |  |
|--|--|---|---|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   | REG. NO. 7 9 2 7 4 9 8                        |   |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary Elizabeth Jacobs   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 25 '79 |   |  |  | 2b. HOUR<br>11:57 AM                    |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 25 21  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hosp |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Assembly         |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bendix Corp   |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Balto. Co.                     |   | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>919 Imperial Ct. |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel T. Jacobs   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl Samons   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>404-20-2323   |   | 17. INFORMANT ADDRESS<br>Balto. 21227<br>Arthur J. Faid 919 Imperial Ct.  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory &amp; Cardiac arrest.</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Malignant Pulmonary tumor (Rt) &amp; Brain Metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Rt lobar pneumonia.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-18-78</u> 19 <u>78</u> , to <u>11-25</u> 19 <u>78</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-25</u> 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br>Myeung Jim Lim   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11/25/78   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Myeung-Jim Lim  |  |   |   | 22e. ADDRESS<br>South Baltimore General Hosp.   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/28/79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                     |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce 4001 Ritchie Hwy   |  |   |   | 25. DATE REC'D. BY REGISTRAR<br>NOV 29 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |   |  |  |



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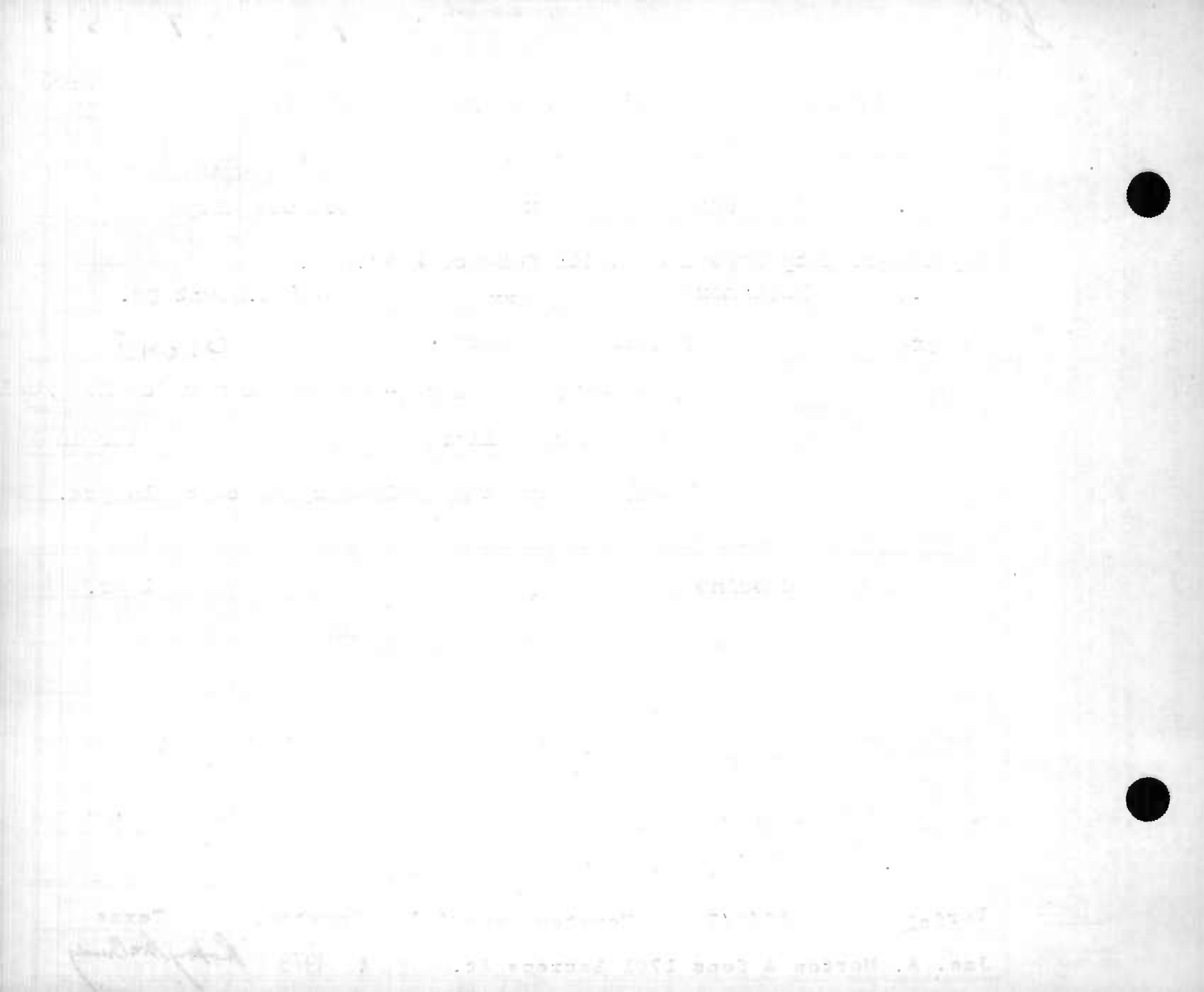


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 9 2 7 4 9 9  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Irene Lockwood Jeffers  |  |   |  | 2a. DATE OF DEATH<br>11/29/79  |  | 2b. HOUR<br>8:00 PM  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Black   |  | 5 DATE OF BIRTH<br>8/11/22   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>La.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>US Public Health Service Hosp. Hwf. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Hwf.  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. STREET ADDRESS<br>1818 N. Mount St.   |  |
| 14. FATHER'S NAME<br>Henry Lockwood   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Mary O. Doms   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>435-10-1275   |  | 17. INFORMANT ADDRESS<br>Records- US Public Service Hospital   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic obstructive pulmonary disease</u> 10 yrs.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>terminal</u> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Esophageal carcinoma</u> 1 yr.  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/24/79</u> 19 <u>79</u> to <u>11/29</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/29</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br>Judith Dillman MD   |  |   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>11/30/79   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Judith Dillman MD.   |  |   |  | 22d. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12/8/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Houston Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Houston, Texas   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jas. A. Morton & Sons 1701 Laurens St.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Rafaela M. Brady   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLARENCE A. JEFFERSON</b>  |  |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>30</b> YEAR <b>79</b> |   |  | 2b. HOUR <b>1145</b> M  |  |
| 3. SEX <b>M</b>   |  | 4. RACE <b>N</b>   |  | 5. DATE OF BIRTH MONTH <b>8</b> DAY <b>13</b> YEAR <b>26</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BOUTH CA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN</b>  |  |
| 13a. STATE <b>MD</b>  |  |  |  | 13b. COUNTY <b>BALTO</b>  |  | 13c. CITY OR TOWN <b>BALTO</b>  |  |
| 14. FATHER'S NAME FIRST <b>TALMADGE</b> MIDDLE <b>JEFFERSON</b> LAST <b>JEFFERSON</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>LENORA</b> MIDDLE <b>GRIM</b> LAST <b>GRIM</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>251-42-3173</b>  |  | 17. INFORMANT <b>Mrs. Maryjorie Jefferson</b> ADDRESS <b>1017 Rose Dale St.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>2030</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MULTIPLE MYELOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>7 MONTHS</b>   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 MONTHS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>MAY</b> 19 <b>79</b> to <b>MAY 30</b> 19 <b>79</b> , that (I) <del>was</del> last saw the deceased alive on <b>Nov. 30</b> 19 <b>79</b> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Yvonne R. Heyman MD.</b> DEGREE <b>MD.</b>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED <b>11/30/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MEYER R. HEYMAN MD.</b>  |  |  |  | 22e. ADDRESS <b>BALTO MD 21215 2435 W. BELVEDERE AVE</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>12/4/1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arbuthnot Ave. Pl.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Herbert E. Hutter</b> ADDRESS <b>3035 W. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Robert A. Hutter</b>  |  |



100% COTTON FIBRE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                       |   |  | 7 9 2 7 5 0 1  |  |   |  |                        |                       |     |
|--|-----------------------|---|--|--|--|---|--|------------------------|-----------------------|-----|
| 1. FOR STATE REGISTRAR   |                       |   |  | REG. NO.   |  |   |  |                        |                       |     |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Primus JEFFERSON</b>   |                       |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>November 22, 1979</b>  |  | 2b. HOUR <b>11:32p M</b>  |  |                        |                       |     |
| 3. SEX <b>Male</b>   |                       | 4. RACE <b>Col</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>3 30 19 60</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) <b>60</b> YRS. <table border="1"><tr><td>IF UNDER 1 YEAR MONTHS</td><td>IF UNDER 24 HRS HOURS</td><td>MIN</td></tr></table> |  | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS HOURS | MIN |
| IF UNDER 1 YEAR MONTHS   | IF UNDER 24 HRS HOURS | MIN   |  |  |  |   |  |                        |                       |     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>  |                       | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |                        |                       |     |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>longshoreman</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                        |                       |     |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>   |                       | 13b. CITY OR TOWN <b>Balto</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS <b>764 Dolphin St</b>   |  |                        |                       |     |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>William Jeffereson</b>  |                       | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Dix</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  |                        |                       |     |
| 16a. SOCIAL SECURITY NO. <b>250-28-8512</b>  |                       | 17. INFORMANT ADDRESS <b>Willie Miloccerson-4637 Park Heights Ave</b>   |  |  |  |   |  |                        |                       |     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gastrointestinal Cancer</b><br><b>1599</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>with Metastasis</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>                         |                       |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |                       |     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |                       |   |  |  |  |   |  |                        |                       |     |
| 19a. DATE OF OPERATION   |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |                        |                       |     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                       | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                        |                       |     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                        |                       |     |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 20, 1979</b> to <b>November 22, 1979</b> , that (we) last saw the deceased alive on <b>November 22, 1979</b> , and that in <b>our</b> opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. |                       |   |  |  |  |   |  |                        |                       |     |
| 22b. SIGNATURE <b>Mark Davis M.D.</b>  |                       |   |  | DEGREE <b>MD</b>   |  | 22c. DATE SIGNED <b>November 22, 1979</b>   |  |                        |                       |     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark Davis, M.D.</b>  |                       |   |  | 22e. ADDRESS <b>Maryland General Hospital</b>  |  |   |  |                        |                       |     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                       | 23b. DATE <b>11-27-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Community Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sumpter S.C.</b>   |  |                        |                       |     |
| 24. FUNERAL DIRECTOR NAME <b>Powell F/H 3197 Schroeder St</b>  |                       |   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>P. F. Schroeder</b>   |  |                        |                       |     |

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November 22, 1973

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Baltimore City

Baltimore General Hospital

William  
D. Davis  
M.D.  
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244 Dolphin St

Cardiovascular Center

with

November 22, 1973

William D. Davis

Baltimore General Hospital



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |   |   |  |  |
|---|--|--|--|---|--|--|---|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  |   | 7 9 2 7 5 0 2<br>REG. NO.  |  |   |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PATRICIA ANN JENKINS</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 24 79</b>   |  |   |   |   | 2b. HOUR<br><b>11:10 AM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 22 77</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>35 hrs.</b>                              |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>1 1</b>  |   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>1 1</b>                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore city Hospital.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>511 N. Linwood Avenue</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael A. Jenkins</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Arlene S. Andrews</b>  |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>---</b>                                 |   | 17. INFORMANT<br>ADDRESS<br><b>511 N. Linwood Avenue</b><br><b>Michael A. Jenkins Balto. MD 21224</b>  |  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>7689 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Mucous aspiration, Persistence fetal circulation, 35 Hrs</b><br>(c) <b>Birth Asphyxia</b>                        |  |  |  |   |  |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>50 minutes</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>9 9</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>@ayumi</b>   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>11/24/79</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>@AYUMI</b>  |  |  |  |   | 22e. ADDRESS<br><b>BALTIMORE CITY HOSPITAL.</b>  |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11/27/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Baltimore, MD</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b><br>ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 9 2 7 5 0 3  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>William JENNINGS</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 17, 1979</b>   |  |  |  |
| 3 SEX<br><b>Male</b>   |  |   |  | 2b. HOUR<br><b>11:05p<sub>M</sub></b>  |  |  |  |
| 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>June 9 1900</b>                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                    |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  | 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mill Worker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. CITY OR TOWN<br><b>Mount Gaithersburg</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Thomas</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lawhorn</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>unknown</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>251-16-0237</b>   |  | 17. INFORMANT<br><b>Medical Record</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>496 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Chronic Obstructive Pulmonary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1977</b>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>10-17-79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Fracture Right Hip</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)            |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 18, 19 79</b> , to <b>November 17, 19 79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 17, 19 79</b> , and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (view) the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Paul A. Tudder M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11/18/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul A. Tudder, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>11/19/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Anatomy Board</b>  |  |   |  | 24b. ADDRESS<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1979</b>  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. McCready</b>  |  |  |  |

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Naval and General Hospital

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California

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TO HOSPITAL/ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9 2 7 5 0 4  
CERTIFICATE OF DEATH

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |                         |   |  |  |   |  |   |   |  |  |
|---|--|-------------------------|---|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jorgen H. JENSEN</b> |  |                         | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>10</b> YEAR <b>79</b>   |  |  | 2b. HOUR<br><b>6:10 P.M.</b>  |  |   |   |  |  |
| 3. SEX<br><b>MALE</b>                                       |  | 4. RACE<br><b>White</b> |   | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>9</b> YEAR <b>25</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |   | 8. IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Denmark</b> |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>               |  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL CORP.</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Payroll Clerk</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b>                 |  |  |

|   |  |  |                          |  |  |   |  |  |                                     |  |  |   |  |  |  |  |  |
|---|--|--|--------------------------|--|--|---|--|--|-------------------------------------|--|--|---|--|--|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  | 13a. STATE<br><b>MD.</b> |  |  | 13b. COUNTY<br><b>BALTO.</b>  |  |  | 13c. CITY OR TOWN<br><b>Dundalk</b> |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>1733 BROOKVIEW RD.</b> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Hans</b> MIDDLE <b>Aaga</b> LAST <b>Jensen</b>            |  |  |                          |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ella</b> MIDDLE <b>Ruth</b> LAST <b>Hohn</b> |  |  |                                     |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |  |  |                          |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>217-34-3409</b>      |  |  |                                     |  |  | 17. INFORMANT<br>ADDRESS <b>1733 Brookview Rd. Balto. MD 21222</b><br><b>Lorraine Jensen</b>    |  |  |  |  |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF LUNG AND LIVER METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>FEW HOURS</b> |  |
|---|--|---|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |

|   |  |   |  |                                     |  |
|---|--|---|--|-------------------------------------|--|
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 10, 1979</b> , to <b>NOVEMBER 10, 1979</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 10, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |  |                                     |  |
| 22b. SIGNATURE<br><b>Fahim Khorfan</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/10/79</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Fahim Khorfan</b>   |  | 22e. ADDRESS<br><b>1711 Hampshire Green Lane Apt # 21 Silver Spring, MD 20903</b>   |  |                                     |  |

|  |  |                              |  |  |  |   |  |
|--|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>11/13/79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b> |  |                              |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1979</b>       |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ruth Hohn</b>  |  |

BP.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |  |                |   |                  |   |                          | REG. NO. 27505                               |          |
|---|---------|--|--|--|----------------|---|------------------|---|--------------------------|--|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE   |                | LAST  |                  | 2a. DATE KNOWN OF DEATH   |                          | 2b. HOUR                                     |          |
| ANTHONY   |         | D.   |  | JOHNS  |                |   |                  | 11 22 1979  |                          | M  |          |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  | IF UNDER 1 YR. |   | IF UNDER 24 HRS. |   | 2c. DATE PRONOUNCED DEAD |  | 2d. HOUR |
| male  | negro   | 11 26 62   |  | 16 YRS.  |                |   |                  |   | 11 22 1979               |  | 9:10 a M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                  |   |                          |  |          |
| Maryland  |         | U. S. A.   |  |  |                | Baltimore City MD.  |                  |   |                          |  |          |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                          |  |          |
| Baltimore   |         | Lutheran Hospital  |  |  |                |   |                  |   |                          |  |          |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         |  |  |  |                |   |                  |   |                          |  |          |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                | 13d. INSIDE CITY LIMITS?  |                  | 13a. STREET ADDRESS   |                          |  |          |
| Maryland  |         |  |  | Baltimore  |                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  | 4860 Carmine Avenue   |                          |  |          |
| 14. FATHER'S NAME   |         |  |  | 15. MOTHER'S MAIDEN NAME   |                |   |                  |   |                          |  |          |
| FIRST MIDDLE LAST   |         |  |  | FIRST MIDDLE LAST  |                |   |                  |   |                          |  |          |
| Daniel J. Johns   |         |  |  | Hannah L. Chavis   |                |   |                  |   |                          |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |         |  |  | 16b. SOCIAL SECURITY NO.   |                | 17. INFORMANT ADDRESS   |                  |   |                          |  |          |
| No  |         |  |  |  |                | Deborah Chavis 2733 Harlem Avenue                                   |                  |   |                          |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot wound of abdomen (unspecified weapon)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |         |  |  |  |                |   |                  |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |         |  |  |  |                |   |                  |   |                          |  |          |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |                |   |                  | 20. AUTOPSY?  |                          |  |          |
|   |         |  |  |  |                |   |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          |  |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |                |   |                  |   |                          |  |          |
|   |         | 12:22xx 11-22-1979   |  | Subject shot.  |                |   |                  |   |                          |  |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION  |                |   |                  |   |                          |  |          |
|   |         | street   |  | 4500 blk. Edmondson Ave., Balto. CITY OR TOWN COUNTY STATE Md.   |                |   |                  |   |                          |  |          |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 11-22-79          |         |  |  |  |                |   |                  |   |                          |  |          |
| ACTUAL SIGNATURE  |         | EXAMINER'S NAME (TYPE OR PRINT) ADDRESS  |  |  |                |   |                  |   |                          |  |          |
|   |         | Ann M. Dixon, M.D. 111 Penn St.  |  |  |                |   |                  |   |                          |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                |   |                  | 23d. LOCATION   |                          |  |          |
| Burial  |         | 11/28/79   |  | Mount Auburn Cemetery  |                |   |                  | Baltimore, Maryland COUNTY STATE                                    |                          |  |          |
| 24. FUNERAL DIRECTOR  |         |  |  |  |                | 25a. DATE REC'D. BY REGISTRAR                                       |                  | 25b. REGISTRAR'S SIGNATURE  |                          |  |          |
| NAME Wm. C. March F/H 1101 East North Avenue ADDRESS  |         |  |  |  |                | NOV 27 1979   |                  | [Signature]   |                          |  |          |

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

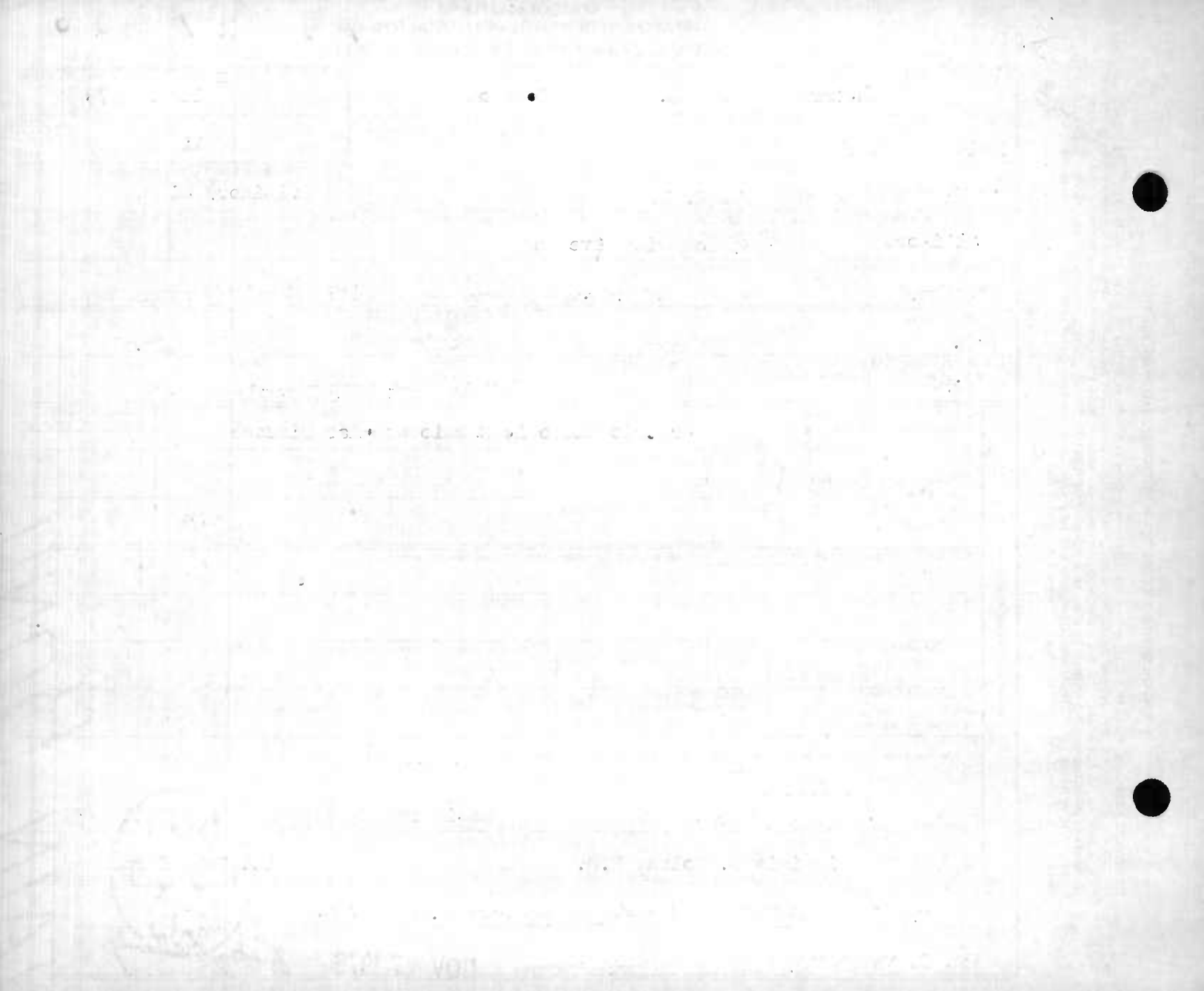
• 012 • EV 100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |   |  |   |  | REG. NO. 27506  |  |
|--|--|------------------|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Andrew  |  | MIDDLE<br>J. L.  |  | LAST<br>Johnson   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11 6 1979  |  | 2b. HOUR<br>M<br>12:58  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 2 1911   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>68 YRS.                               |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 6 1979                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2445 Lakeview Avenue |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2445 Lakeview Avenue   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Johnson   |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Wood  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br>Lela West 1515 Lanvale Street                        |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: Arteriosclerotic Cardiovascular Disease<br>4292<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |  |                  |  | TITLE (SPECIFY)<br>Assistant   |  |   |  | DATE SIGNED<br>11/6/79  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |  |                  |  | ADDRESS<br>111 Penn Street   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>11/10/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Maryland   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 East North Avenue  |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1979                                   |  | 25b. REGISTRAR'S SIGNATURE<br>R. H. H. H.   |  |   |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | BERTHA E. JOHNSON  |  |   |  | 7 9 27507  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>LAST <u>JOHNSON</u> , FIRST <u>BERTHA</u> , MIDDLE <u>E.</u>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>11-17-79</u> 2b. HOUR<br><u>12:30 PM</u>      |  |  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>June 7, 1899   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto City MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Union Memorial Hospt. |  |   |  | 12a. USUAL OCCUPATION (1. HOMEWORKER OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>--  |  | 13c. CITY OR TOWN<br>Balto City   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3711 Alameda Circle   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Karl Vogel   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Wilhelmina Ziegler |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>220-44-4233            |  | 17. INFORMANT ADDRESS<br>Miss Thelma E. Johnson-3711 Alameda Cir.   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u><br><u>410-</u> DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>PULMONARY EDEMA, RENAL FAILURE</u>   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>11-17-</u> 19 <u>79</u> , to <u>11-17-</u> 19 <u>79</u> , that (we) lost saw the deceased alive on <u>11-17-</u> 19 <u>79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Dennis J. Chadnicki</u> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |  |   |  | 22c. DATE SIGNED<br><u>11-17-79</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dennis J. Chadnicki  |  |  |  | 22e. ADDRESS<br>Union Mem. Hospt.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/20/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto Co.                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>Mitchell-Wiedefeld Home-6500 York Rd. 21212   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony M. Brady</u>  |  |

June 7, 1952

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |   |                            | 7 9 27 508  |  |
|---|--|--|--|---|--|--|--|---|----------------------------|---|--|
| 1 - STATE REGISTRAR   |  |  |  |   |  |  |  |   |                            | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CATHERINE JOHNSON</b>   |  |  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 22 79</b> |   | 2b. HOUR<br><b>5:15 AM</b> |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 08 24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |                            |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.                        |  |   |                            |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                            |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD. Harford Belair</b>   |  |  |  |   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN          |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Cromwell</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Peaker</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>W. Hall ST.</b>  |  |   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-22-0754</b>   |  | 17. INFORMANT<br><b>Maybell Hash</b>  |  | ADDRESS<br><b>986 Argonne Dr. Baltimore Md.</b>                                      |  |   |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |  |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Metastatic adenocarcinoma</b>  |  |  |  |   |  |  |  |   |                            |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |                            |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |                            |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> , 19 <b>79</b> , to <b>11/22</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/22</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, please so state and view the body after death.)  |  |  |  |   |  |  |  |   |                            |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>11/22/79</b>   |                            |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Roca</b>   |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |   |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-27-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Berkley</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Darlington, Harford MD</b>          |  |   |                            |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Arnold W. Beard</b>  |  |  |  | ADDRESS<br><b>117 E Cecil Ave North east Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                            |   |  |

MEDICAL CERTIFICATION

22 45 808



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |  |   |  |  |   | 7  | 9 | 2  | 7  | 5   | 0   | 9  |  |  |  |
|---|--|--|---|---|--|---|--|--|---|--|---|--|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   |  |   |  |  |   | REG. NO.   |   |  |  |   |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CARENCE JOHNSON</b>   |  |  |   |   |  |   |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 18 79</b>                                  |   |  |  | 2b. HOUR<br><b>10<sup>30</sup> PM</b>   |   |  |  |  |  |
| 3. SEX<br><input checked="" type="checkbox"/> MALE  |  |  | 4. RACE<br><b>BLACK</b>   |   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 5 12</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                 |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Unknown</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |  |   |  |  |   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MD. HOSPITAL</b> |   |  |   |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>      |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>W.T. Burnett</b>   |   |   |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  |   |   |  |   |  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2464 NEVADA STREET</b> |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>LOUIS JOHNSON</b>   |  |  |   |   |  |   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARY CORNISH</b>                    |   |  |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No.</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-10-5489</b>  |   |  | 17. INFORMANT ADDRESS<br><b>HANNAH JOHNSON 2464 Nevada St.</b>  |  |  |   |  |   |  |  |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4280</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>50 minutes</b><br><b>13 years</b> |  |  |   |   |  |   |  |  |   |  |   |  |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |   |  |  |   |  |   |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |   |  |  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 14</b> , 19 <b>79</b> , to <b>November 18</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>November 18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |  |   |  |   |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Raymond Flores MD</b>  |  |  |   |   |  |   |  |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>11/18/79</b>              |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYMOND FLORES MD</b>   |  |  |   |   |  |   |  |  |   | 22e. ADDRESS<br><b>University of Maryland Hospital</b>                               |   |  |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |   | 23b. DATE<br><b>11/21/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>  |  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Arbutus Co. Md.</b>                    |   |  |  |   |   |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Charles A. Rice</b>   |  |  |   |   |  |   |  |  |   | ADDRESS<br><b>1390 Eutaw Place</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b> |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 7 9 2 7 5 1 0   |   |
|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Elaine Johnson</b>  |  |   | 2a. DATE OF DEATH<br><b>November 5 1979</b>  |   | 2b. HOUR<br><b>5:14 PM</b>  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>3</b> YEAR <b>1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                 | IF UNDER 1 YEAR<br>MONTHS <b>70</b> DAYS <b>70</b> HOURS <b>70</b> MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                 |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                       |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>MONKTON</b>  |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS<br><b>Big Falls Rd - Monkton, Md.</b> |   |   |
| 14. FATHER'S NAME<br>FIRST <b>Sherman</b> MIDDLE <b>Hall</b> LAST <b>Hall</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Maria</b> MIDDLE <b>Robinson</b> LAST <b>Robinson</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-19-3710D</b>   |  | 17. INFORMANT<br><b>Myrtle Lee Western</b> ADDRESS <b>1353 Western Run Rd</b>     |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b><br>5789<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pulmonary edema</b><br>(c) <b>Upper gastro-intestinal bleeding</b>                                  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>October 31</b>       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 31</b> , 19 <b>79</b> , to <b>November 5</b> , 19 <b>79</b> , that (X) (we) lost saw the deceased alive on <b>November 5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Eric Fisher</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11-5-79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eric Fisher, M.D.</b>  |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11/9/79</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Balto.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>    |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Chitman #H</b> ADDRESS <b>1701 McCulloch St</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. Kelly</b>                                  |   |

BP





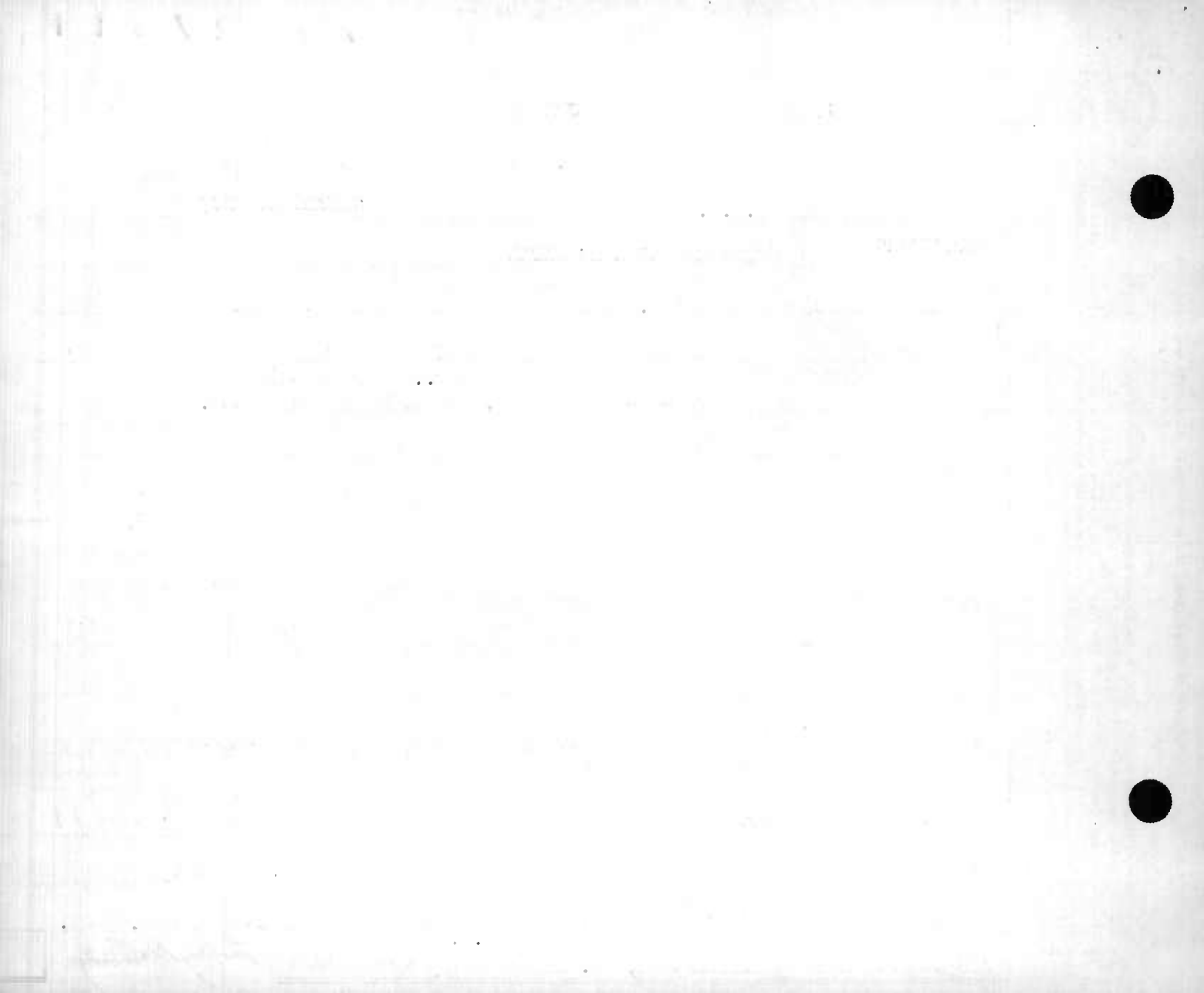
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |   |  |  | 79   | 27511 |
|---|--|---|--|---|---|--|---|--|--|--|-------|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | REG. NO.  |  |   |  |  |  |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GRACE JOHNSON</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 28 1979</b>    |  |   |  |  | 2b. HOUR<br><b>4 AM</b>                      |       |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 7, 1897</b>   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |       |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |       |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>                             |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>3514 Old Mill Road</b>   |  |       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ansel Hilstein</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Row</b> |  |   |  |  |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>none</b>  |  | 17. INFORMANT<br><b>Mr. Mayer Plotkin</b>   |   |  | ADDRESS<br><b>600 W. Franklin Street Balto. Md. 21201</b>                                       |  |  |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septis</b><br><b>436-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebrovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>28 days</b> |  |   |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Old inferior myocardial infarction, congestive heart failure, renal insuff.</b>   |  |   |  |   |   |  |   |  |  |  |       |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |       |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>October 31 1979</b> to <b>November 28 1979</b> that (1) (we) last saw the deceased alive on <b>November 27 1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |  |  |  |       |
| 22b. SIGNATURE<br><b>Geraldine J. Keyes, M.D.</b>   |  |   |  |   | DEGREE<br><b>M.D.</b>   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/28/79</b>          |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Geraldine J. Keyes, M.D.</b>  |  |   |  |   | 22e. ADDRESS<br><b>Union Memorial Hospital</b>                    |  |   |  |  |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>11/29/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olive Cemetery</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Balto. MD.</b>   |  |  |       |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, F.A.</b>   |  |   |  |   | ADDRESS<br><b>8728 Liberty Road Randallstown, MD. 21133</b>       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony A. Brady</b>  |  |       |

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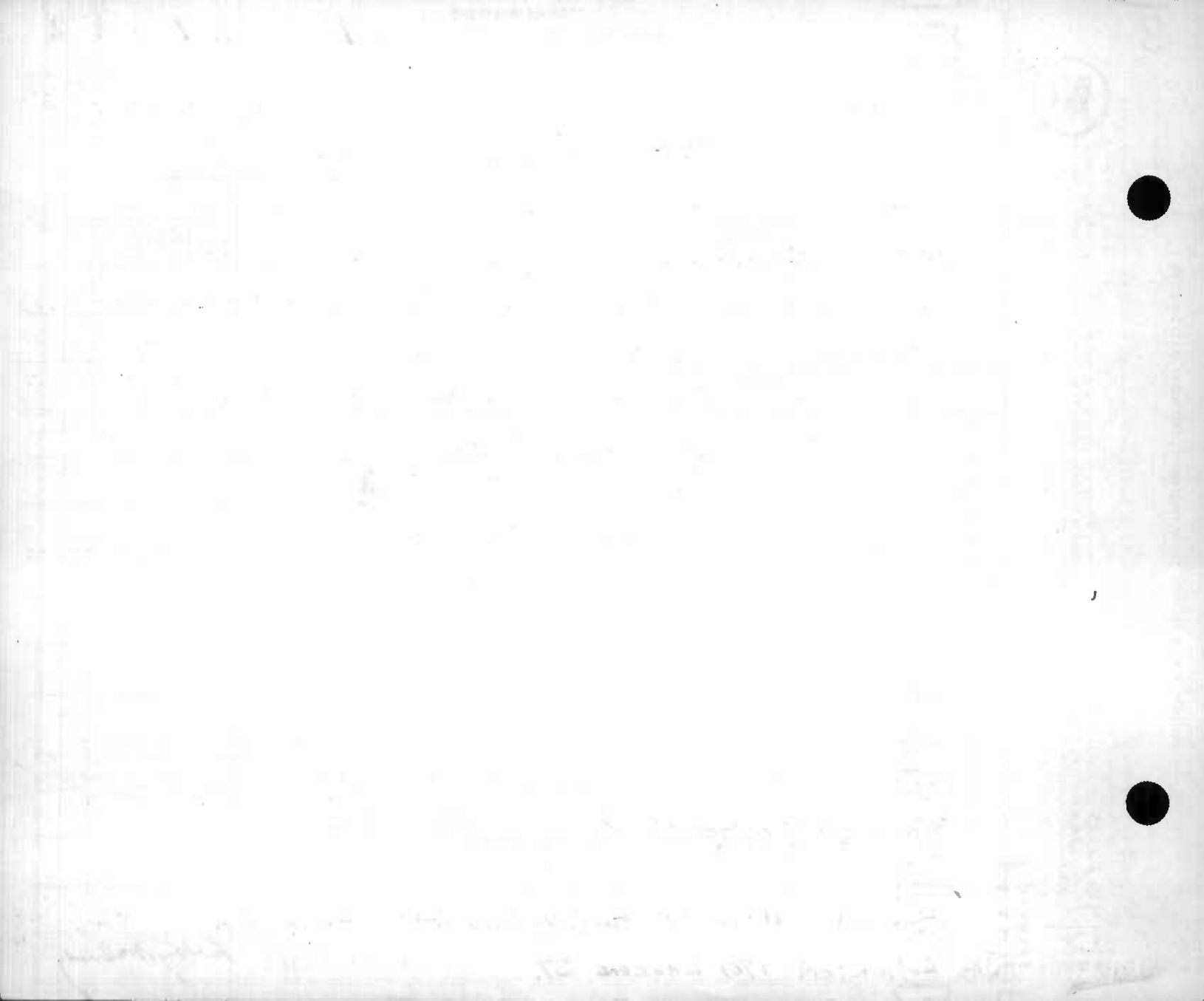


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 7 9 2 7 5 1 2   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1 - STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>MARION JETER JOHNSON</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 10 1979</b>  |  | 2b. HOUR <b>4:35 P.M.</b>   |  |
| 3 SEX <b>F</b>  |  | 4 RACE <b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 16 1904</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA-USA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DIS. PUBLIC HEALTH SERVICE HOSP.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>-</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>SHIRLEY JETER</b>   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAMMA CLARK</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO <b>216-18-9339</b>  |  | 17 INFORMANT <b>SARA JOHNSON (Daughter)</b>  |  | ADDRESS <b>WILLINGS BEAM, M.D. 1701 LAURENS ST.</b>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CORONARY THROMBOSIS</b><br>(c) <b>ARTERIO SCLEROSIS</b> |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>BRONCH PNEUMONIA (R &amp; L); ARTERIO SCLEROSIS</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Doc Schuchman M.D.</b>  |  |  |  | DEGREE  |  | 22c. DATE SIGNED  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22c. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>11-16-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT.</b>  |  | 23d. LOCATION CITY OR TOWN* COUNTY STATE <b>ARLINGTON VA.</b>   |  |
| 24 FUNERAL DIRECTOR NAME <b>JAS. A. MORTON</b> ADDRESS <b>1701 LAURENS ST.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

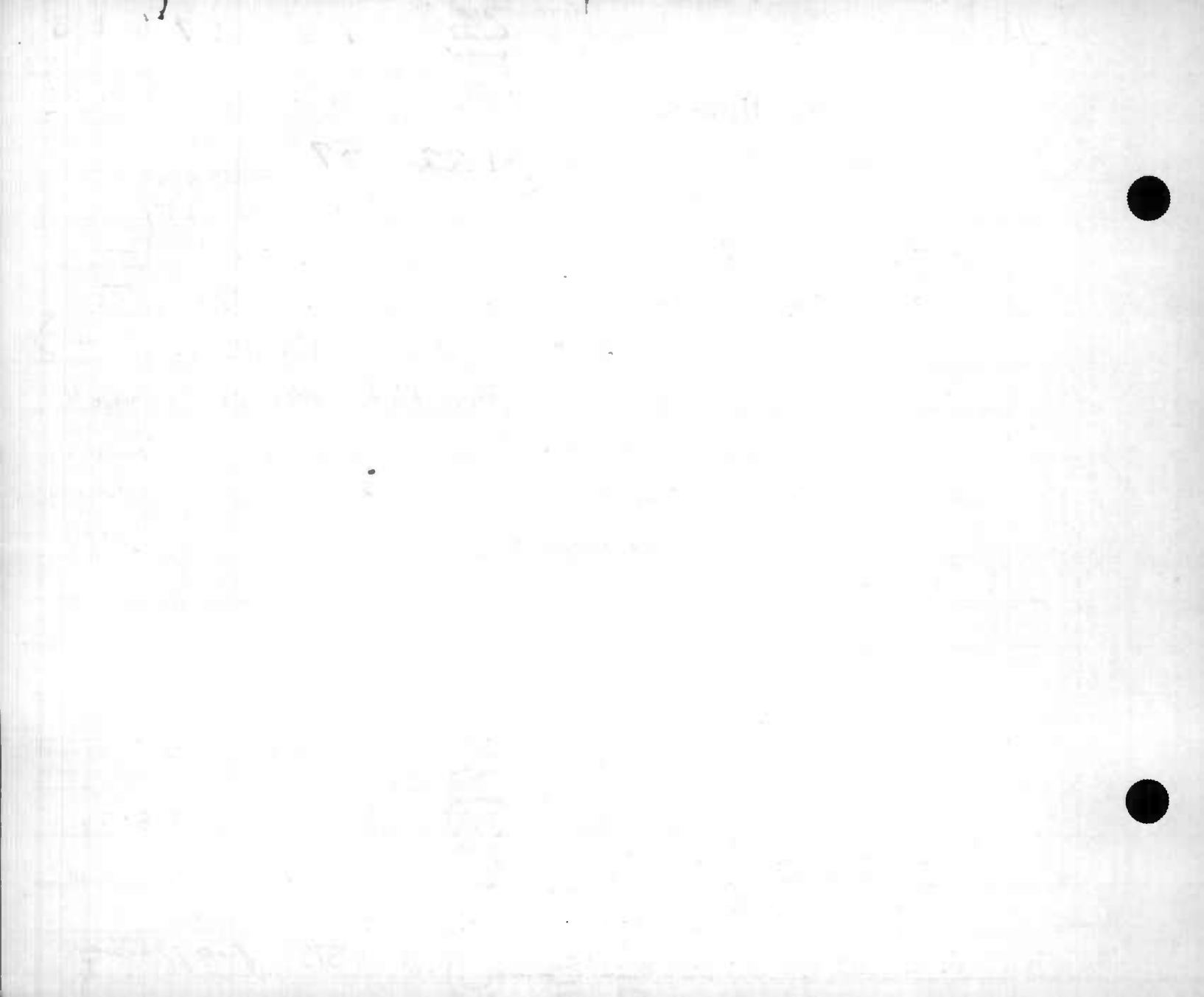
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 5 1 3

REG. NO.

|   |  |  |   |  |   |  |  |   |  |
|---|--|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY Martha JOHNSON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-5-79</b> |  | 2b. HOUR<br><b>10<sup>50</sup> AM</b>   |  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 31 22</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b><br>YRS. MONTHS DAYS<br>IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN. |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BERC</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>unemployed</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |   |  |  |   |  |
| 13a. STATE<br><b>MO</b>   |  | 13b. COUNTY<br><b>BALT.</b>  |   | 13c. CITY OR TOWN<br><b>BALT</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 13e. STREET ADDRESS<br><b>1416 W. Lafayette</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MOSES BROADWAY</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY wells (Vincent)</b>   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-36-8470</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>ANNA Ricks 1416 West LAFAYETTE</b>  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>3485</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>STATUS EPILEPTICUS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebral exsion</b> |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hrs</b><br><b>2 days</b><br><b>10 days</b>                           |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Breast carcinoma</b>   |  |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |
| 22. I certify that (1) (this hospital attended the deceased from <b>July</b> 19 <b>79</b> to <b>Nov 5</b> 19 <b>79</b> ), that (2) (we) last saw the deceased alive on <b>Nov 5</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.   |  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>B.W. Dimery</b>  |  |  |   | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |  | 22c. DATE SIGNED<br><b>11-5-79</b>              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B.W. Dimery</b>   |  |  |   | 22e. ADDRESS<br><b>BERC / UNIV of Maryland</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/10/1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Maryland</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 East North Avenue</b>  |  |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 6 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |



## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |   |  |   |  |
|---|--|--|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Peachie P. Johnson</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>7</b> YEAR <b>79</b>             |  |  | 2b. HOUR<br>M   |   |  |   |  |
| 3 SEX<br><b>F</b>   |  | 4 RACE<br><b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>22</b> YEAR <b>99</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS                           |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.          |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>701 Resevior St.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b>   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>701 Resevior St.</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Franklin</b> MIDDLE <b>Patterson</b> LAST   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rebecca</b> MIDDLE <b>Thornton</b> LAST |  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-14-1554</b>                               |  | 17. INFORMANT<br><b>Preston R. Johnson</b>                                     |   |   | ADDRESS<br><b>701 Resevior St.</b>   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial C-V Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Ht. Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4029</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 yrs</b><br><b>at least 10 yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Diabetes mellitus, cataracts (recent surgery)</b>   |  |  |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>10/77</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cataracts</b>         |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>10/30/79</b> to <b>11/7/79</b> , that (2) (we) last saw the deceased alive on <b>10/30/79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)   |  |  |  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>E. S. ANDERS</b>   |  |  | DEGREE<br><b>MD</b>  |  |  | 22c. DATE SIGNED<br><b>11/9/79</b>  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS<br><b>2300 Garrison Pk.</b>                                     |  |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11/12/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Nat. Mem. Pk.</b>                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Md.</b>                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |  |  | ADDRESS<br><b>1101 E. North Ave.</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1979</b>                       |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Halvord</b>  |   |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |  |                |   |                         |                                    |   | 9 27515<br>REG. NO.   |          |  |                   |   |                     |
|---|---------|--|--|--|----------------|---|-------------------------|------------------------------------|---|---|----------|--|-------------------|---|---------------------|
| 1. FOR STATE REGISTRAR  |         | 1. DECEASED NAME<br>(TYPE OR PRINT)                      |  | FIRST  | MIDDLE         | LAST  | 2a. DATE KNOWN OF DEATH |                                    | <input checked="" type="checkbox"/> MONTH | DAY   | YEAR     | 2b. HOUR                                     |                   |   |                     |
|   |         | Timothy Johnson  |  |  |                |   | 11 6 19 79              |                                    |   |   |          | M  |                   |   |                     |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  | IF UNDER 1 YR. |   | IF UNDER 24 HRS.        |                                    | 2c. DATE PRONOUNCED DEAD                  |   | 2d. HOUR |  |                   |   |                     |
| male  | black   | 9 12 70  |  | 9 YRS.   |                |   |                         |                                    | 11 6 19 79                                |   | 9:34 P.  |  |                   |   |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                         |                                    |   | MD.   |          |  |                   |   |                     |
| Maryland  |         | USA  |  |  |                | Baltimore City  |                         |                                    |   |   |          |  |                   |   |                     |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |  |                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                         | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |          |  |                   |   |                     |
| Baltimore   |         | University Hospital                                      |  |  |                | N/A   |                         |                                    |   |   |          |  |                   |   |                     |
| 13a. STATE  |         |  |  |  |                |   |                         |                                    |   |   |          | 13b. COUNTY                                  | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS |
| Maryland  |         |  |  |  |                |   |                         |                                    |   |   |          | —  | Baltimore         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1023 Edmondson Ave  |
| 14. FATHER'S NAME   |         |  |  | 15. MOTHER'S MAIDEN NAME   |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| Samuel Winder   |         |  |  | Pauline Johnson  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         |  |  | 16b. SOCIAL SECURITY NO.   |                |   |                         | 17. INFORMANT ADDRESS              |   |   |          |  |                   |   |                     |
| NO  |         |  |  | —  |                |   |                         | Miss P. Johnson 1023 Edmondson Ave |   |   |          |  |                   |   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |  |                |   |                         |                                    |   |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                   |   |                     |
| PART I DEATH WAS CAUSED BY:   |         |  |  |  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| IMMEDIATE CAUSE (a) Asphyxia following displacement of tracheostomy tube  |         |  |  |  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| 9/138   |         |  |  |  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |         |  |  |  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| (b)   |         |  |  |  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| (c)   |         |  |  |  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                |   |                         |                                    |   | 20. AUTOPSY?  |          |  |                   |   |                     |
|   |         |  |  |  |                |   |                         |                                    |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |  |                   |   |                     |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY  |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                         |                                    |   |   |          |  |                   |   |                     |
|   |         |  |  | ? P.M. 11/6 1979   |                | Displacement of tracheostomy tube   |                         |                                    |   |   |          |  |                   |   |                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                | 21f. LOCATION   |                         |                                    |   | 21g. LOCATION   |          |  |                   |   |                     |
|   |         |  |  | home   |                | 1023 Edmondson Ave., Baltimore City   |                         |                                    |   | MD  |          |  |                   |   |                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| ACTUAL SIGNATURE  |         |  |  | TITLE (SPECIFY)  |                |   |                         | DATE SIGNED                        |   |   |          |  |                   |   |                     |
| Hormez R. Guard, MD   |         |  |  | Assistant  |                |   |                         | 11/7/79                            |   |   |          |  |                   |   |                     |
| EXAMINER'S NAME (TYPE OR PRINT)   |         |  |  | ADDRESS  |                |   |                         |                                    |   |   |          |  |                   |   |                     |
|   |         |  |  | 111 Penn Street, Balto. MD 21201   |                |   |                         |                                    |   |   |          |  |                   |   |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |  |  | 23b. DATE  |                | 23c. NAME OF CEMETERY OR CREMATORY  |                         |                                    |   | 23d. LOCATION   |          |  |                   |   |                     |
| Burial  |         |  |  | 13 Nov. 79   |                | Mt. Auburn Cem.   |                         |                                    |   | Baltimore   |          |  |                   |   |                     |
| 24. FUNERAL DIRECTOR NAME   |         |  |  | ADDRESS  |                | 25a. DATE REC'D. BY REGISTRAR   |                         |                                    |   | 25b. REGISTRAR'S SIGNATURE  |          |  |                   |   |                     |
| Powell F/H  |         |  |  | 319 W. Schroeder St.   |                | NOV 9 1979  |                         |                                    |   |   |          |  |                   |   |                     |

MEDICAL CERTIFICATION

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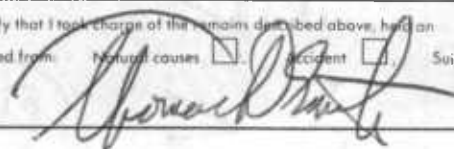
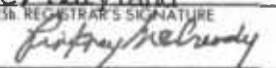
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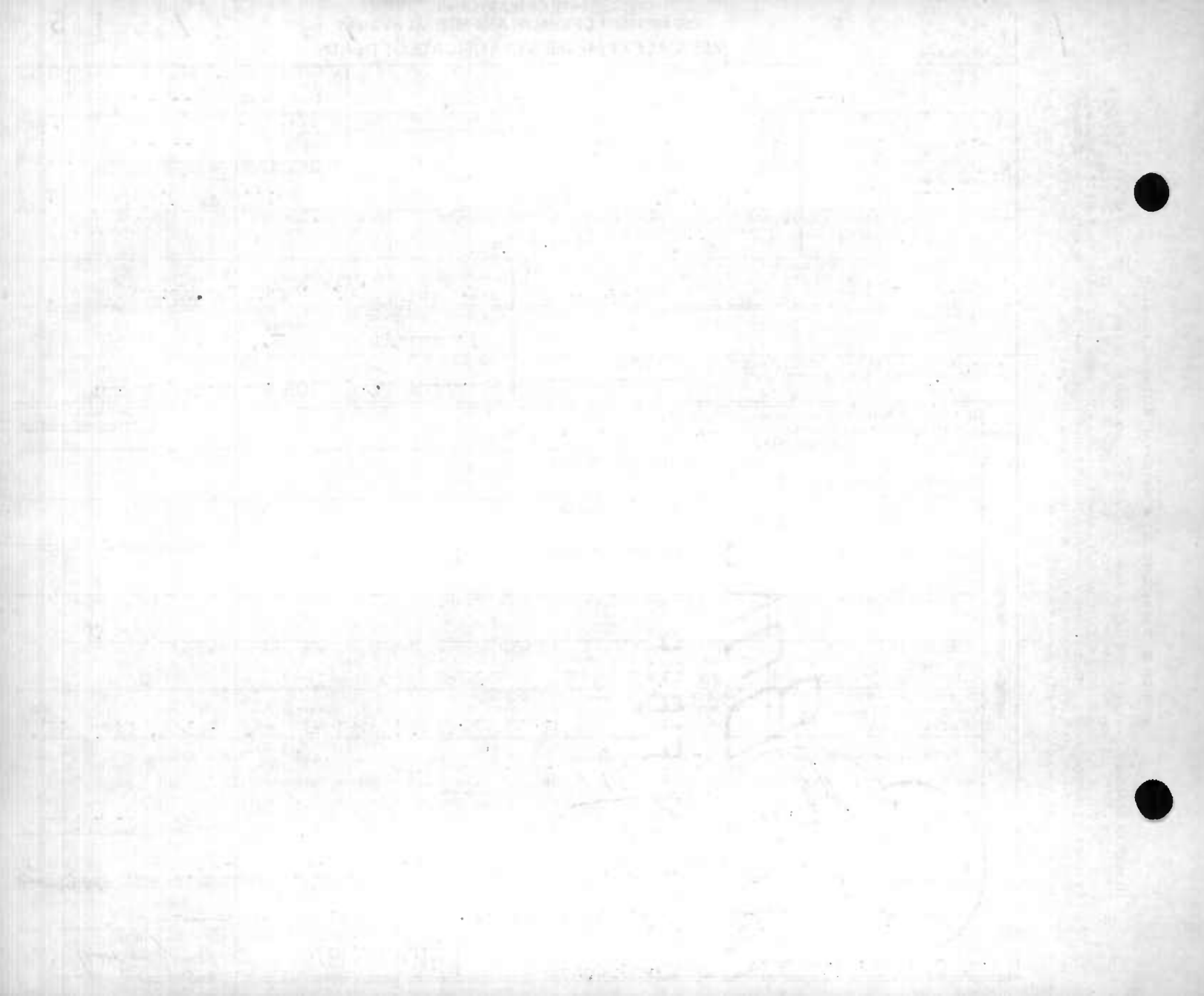
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THIS CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE OF DEATH   |   | 2b. HOUR  |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |   | 2a. DATE OF DEATH   |   | 2b. HOUR  |   |
| FIRST MIDDLE LAST   |   | MONTH DAY YEAR  |   | M   |   |
| Willie E. Johnson   |   | 11 18 1979  |   | 1:08A   |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YR.   | 8. IF UNDER 24 HRS.   |
| Male  | Black   | MONTH DAY YEAR  | YRS.  | MONTHS DAYS   | HOURS MIN.  |
|   |   | 6 9 1953  | 26  |   |   |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 9b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED  | NEVER MARRIED   | WIDOWED   | DIVORCED  |
| Maryland  | U. S. A.  | <input type="checkbox"/>                                    | <input checked="" type="checkbox"/>                                 | <input type="checkbox"/>  | <input type="checkbox"/>  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 9. BALTIMORE CITY OR COUNTY OF DEATH                        |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |   |
| Baltimore City  | 1500 Blk. N. Montford Ave.  | Baltimore City, MD.   |   |   |   |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |   |
| Maryland  |   | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1031 North Broadway   |   |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME  | 16. SOCIAL SECURITY NO.                                     |   |   |   |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST   | 212-60-4835   |   |   |   |
|   | Margaret H. Ford  | Margaret Ford 3309 Ravenwood Avenue                         |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS                                       |   |   |   |
| No  | 212-60-4835   | Margaret Ford 3309 Ravenwood Avenue                         |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART I DEATH WAS CAUSED BY:   |   |   |   |   |   |
| IMMEDIATE CAUSE (a) <u>Stab wound of neck</u>   |   |   |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |   |   |   |
| (b) _____   |   |   |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |   |   |   |
| (c) _____   |   |   |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   | 20. AUTOPSY?  |
|   |   |   |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |   |
|   |   | 1 11 18 1979  |   | stabbed by assailant  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION   |   |
|   |   | street  |   | 1500 Blk. N. Montford Ave. Balto. City, MD.   |   |
| 22a. I certify that I took charge of the remains described above, and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |   |   |   |
| ACTUAL SIGNATURE  |   | TITLE (SPECIFY)   |   | DATE SIGNED   |   |
|   |   | M.D. Deputy Chief   |   | 11/18/79  |   |
| EXAMINER'S NAME (TYPE OR PRINT)   |   | ADDRESS   |   |   |   |
| Thomas D. Smith, M.D.   |   | 111 Penn St. Balto., MD.                                    |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                          | 23d. LOCATION   |   |   |
| Burial  | 11/23/1979  | Baltimore Cemetery  | Baltimore, Maryland   |   |   |
| 24. FUNERAL DIRECTOR NAME   |   | 25a. DATE REC'D. BY REGISTRAR                               |   | 25b. REGISTRAR'S SIGNATURE  |   |
| Wm. C. March F/H 1101 East North Avenue   |   | NOV 20 1979   |   |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO GENERAL PUBLIC: After this certificate has been signed by the attending physician and completely filled in, it should be placed in the container for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 5 1 7

REG. NO.

|   |  |  |   |  |   |  |   |  |   |  |  |
|---|--|--|---|--|---|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Alliefair ALFAIR Green JONES</i>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>NOVEMBER 8, 1979</i>                 |  |   | 2b. HOUR<br><i>12:30 PM</i>  |   |  |   |  |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>NEGRO</i>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>April 3 - 1901</i>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>78</i> YRS.   |   | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><i>78</i>   |   | 7 UNDER 24 HRS.<br>HOURS MIN.<br><i>78</i>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>S.C.</i>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.   |   |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>THE JOHNS HOPKINS HOSPITAL</i> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Domestic</i>   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i> |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><i>Md.</i>  |  |  | 13b COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>1200 McElderry Court</i>  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Sippio Green</i>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Sarah Loyd</i>          |  |   |  |   |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>218-224779</i> |  | 17 INFORMANT ADDRESS<br><i>Mr. MC Neil Green 1208 Glenwood Ave.</i> |  |   |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>SEPTIC SHOCK</i><br><i>7302</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>OSTEOMYELITIS</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>DECUBITI</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>CHRONIC ANEMIA, PANCREATIC MASS</i>  |  |  |   |  |   |  |   |  |   |  |  |
| 19a DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>11/8 1979</i>         |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>601 N Broadway Schuerville S.C.</i>  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/8</i> 19 <i>79</i> , to <i>11/8</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/8</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |   |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Elliot Israel</i>  |  |  | DEGREE  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><i>11/8/79</i>                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Elliot Israel</i>   |  |  | 22e. ADDRESS<br><i>601 N Broadway</i>                                       |  |   |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Removal</i>   |  |  | 23b. DATE<br><i>11-12-79</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Wesley Cemetery</i>        |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Schuerville S.C.</i>  |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Randolph J. Collick 2436 E. Oliver St.</i>  |  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 14 1979</i>  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McBrady</i> |  |  |

PL 001 0 1130

PL 001 0 1130

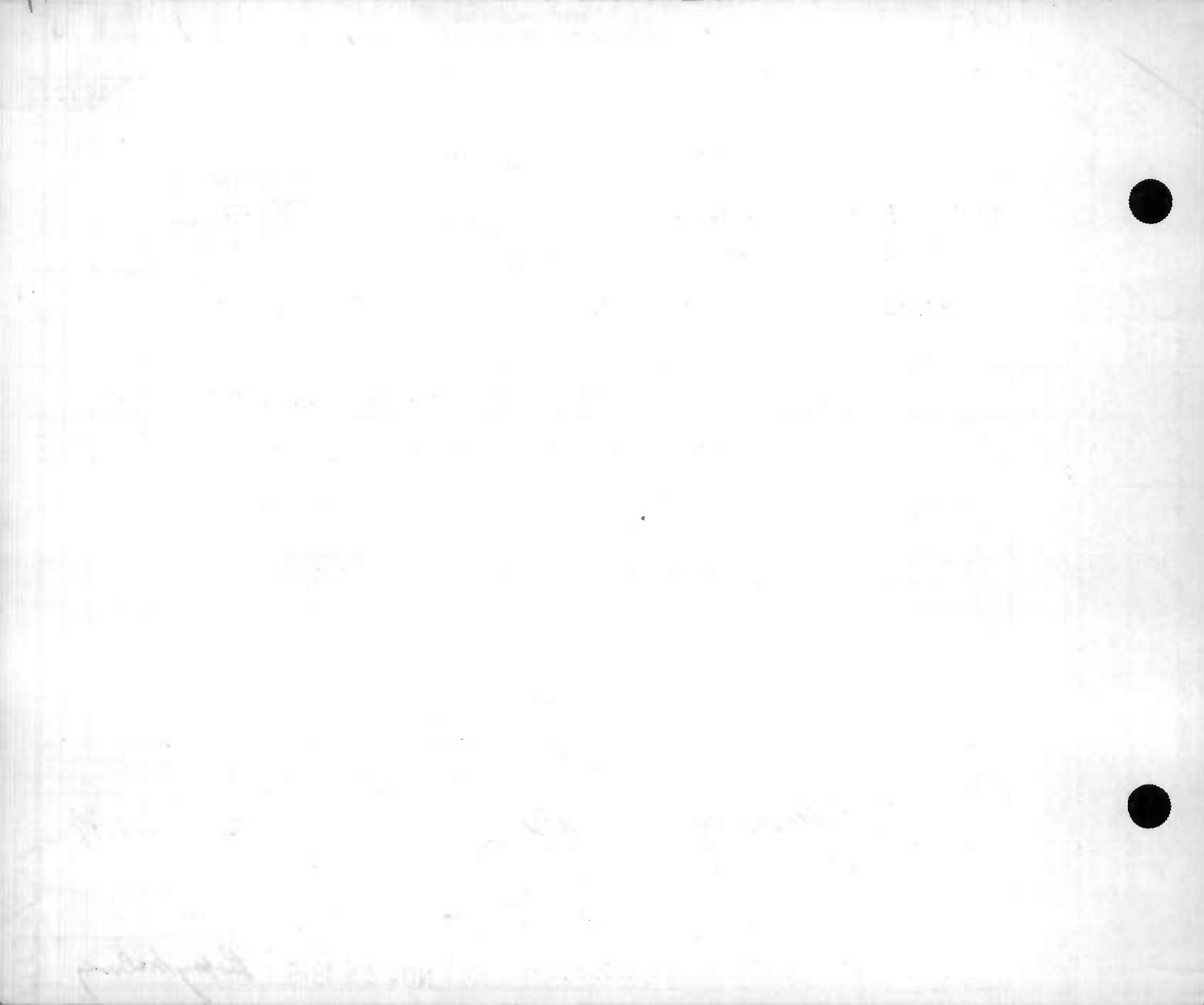
TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 7 5 1 8

REG. NO.

|   |  |   |  |  |  |  |                                |
|---|--|---|--|--|--|--|--------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Dave</b>  |  | LAST<br><b>JONES</b>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 25, 1979</b>   |  | 2b. HOUR<br><b>10:25P</b>  |                                |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Negro</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 16 1892</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |                                |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 16. STREET ADDRESS<br><b>450 Manse Street</b>  |  |  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-05-7587</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mary Barnes 130 North Asquith Street</b>  |  |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Event, Etiology Unknown, Less than 15 mins.</b><br>7999<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  | 18. CAUSE OF DEATH (continued) |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hepatomegaly, XXXXX Shortness of Breath, Right Lower Lobe Infiltrate</b>  |  |   |  |  |  |  |                                |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>Nov. 24 1979</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Nov. 24 1979 Nov. 25, 1979</b>   |  |  |                                |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 24, 1979</b> , to <b>Nov. 25, 1979</b> , that (I) (we) last saw the deceased alive on <b>Nov. 25, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |                                |
| 22a. SIGNATURE<br><i>Paul Gormley</i>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>11/25/79</b>  |                                |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Gormley M. D.</b>  |  | 22d. ADDRESS<br><b>4607 Roland Avenue</b>   |  |  |  |  |                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/30/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Calvary Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |                                |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 East North Avenue</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Richard M. Brady</i>  |                                |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 79 27519   |  | REG. NO.  |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DORIS JONES</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 26 79</b>   |  | 2b. HOUR<br><b>8:00 P.M.</b>  |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 09 05</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ADAM SCHIMSCHEMSKI</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FILIYO PIETRUSENKI</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-9304</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>LEROY PREDIGER, 902 WILTON DRIVE, 21227</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest.</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Anemia</b>  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-26-79</b> , to <b>11-26-79</b> , that (I) (we) last saw the deceased alive on <b>11-26-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>C. Malhotra</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11-27-79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. MALHOTRA, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALTIMORE, MD. 21229</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11-30-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

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900 CATON AVE. BALTIMORE, MD. 21229

NOV 8 1912

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 2 7 5 2 0

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Erma J Jones</b>  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 1, 1979</b>                          |  | 2b. HOUR<br><b>M</b>   |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>White</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 14, 1905</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3601 Southern Ave</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |   |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James T Coulter</b>  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian</b>                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>219-42-1982</b>   | 17 INFORMANT ADDRESS<br><b>Mrs Madeline I Lynch 809 North Shore Dr 21061</b>         |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410- Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Min. years</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>PAST Hx of CHF</b>   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-77</b> 19 to <b>10-30</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>10-30</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                                       |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Philip H. Moore</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br><b>11-2-79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Philip H. Moore</b>  |   | 22e. ADDRESS<br><b>3925 BEECH AVE Balt 21212</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11/5/79</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc, Baltimore, Maryland</b>  |   | ADDRESS  |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 2 1979</b>                                    |  |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 7 9 2 7 5 2 1   |  |
|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ETHEL V. JONES</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-20-79</b>                             |   | 2b. HOUR<br><b>6:15 A.M.</b>                         |
| 3 SEX<br><b>FEMALE</b>  | 4 RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 14 21</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOSTESS</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TRI-CITY</b> |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>ARBUTUS</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROY T. PERRELL</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LEANA ESSWORTHY</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>215-28-9234</b>  |  | 17. INFORMANT ADDRESS<br><b>JOAN M. HALL, 1913 HALETHORPE AVENUE, 21227</b>                     |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute myocardial infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Ventricular arrhythmia, Emphysema</b>   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/17/79</b> , 19 <b>79</b> , to <b>11/20/79</b> , 19 <b>79</b> , that (I) (we) lost the deceased above on <b>11/20/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |   |  |   |  |
| 22b. SIGNATURE<br><b>KYAW NYUNT</b>   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>11/20/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KYAW NYUNT</b>  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALTIMORE, MD. 21229</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11-23-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT OLIVET</b>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1979</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  | 25c. REGISTRAR'S NAME<br><b>FREDERICK FREDERICK</b>   |  |   |  |

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2751

BALTIMORE CITY

BALTIMORE ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL BALTIMORE

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL BALTIMORE

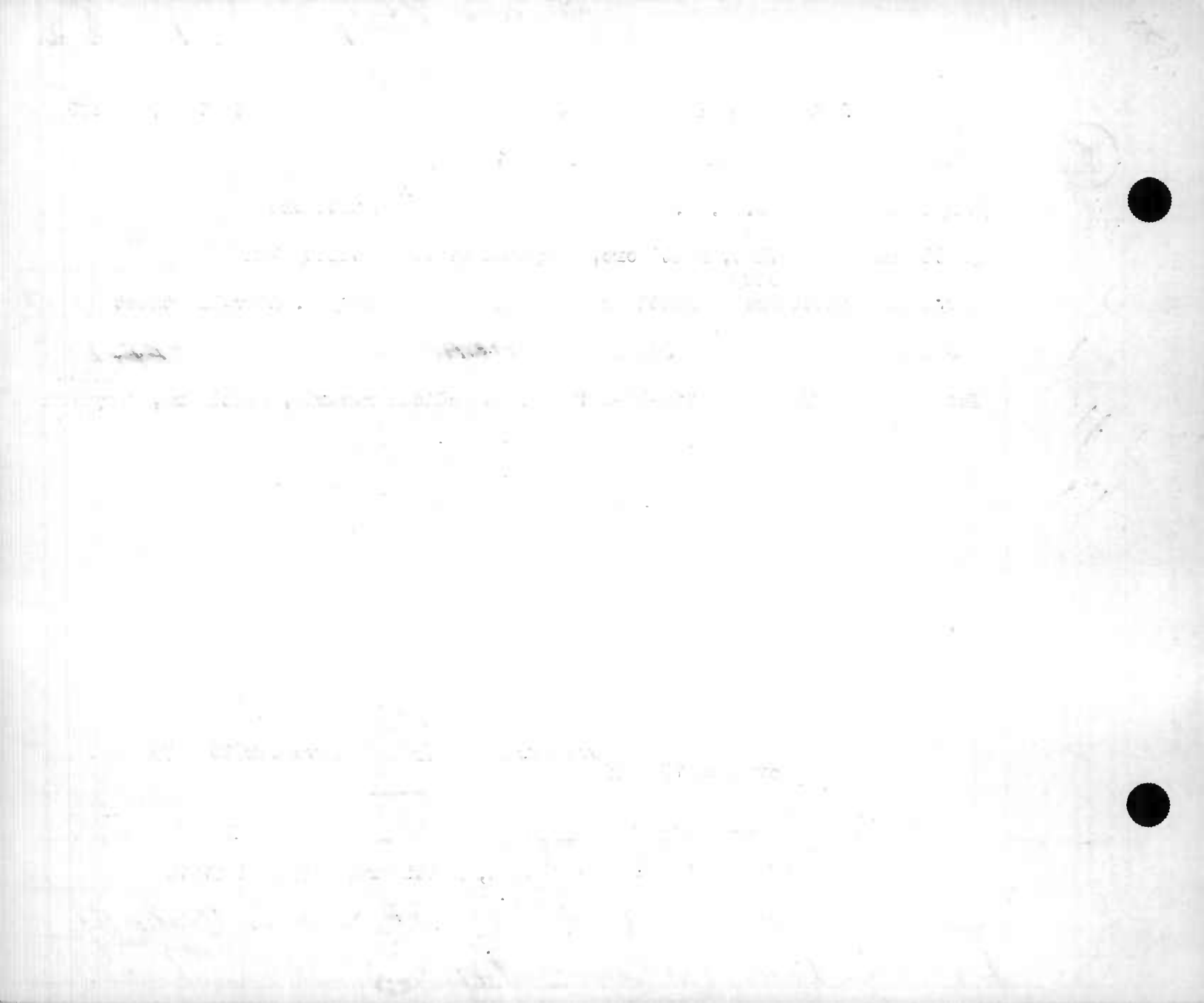
ST. AGNES HOSPITAL BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |   |   |  |
|--|--|--|--|---|--|--|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 2 7 5 2 2  |  |   |  | REG. NO.   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EUGENE LEWIS JONES  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 10 79<br>TIME<br>3:00 P.M.   |  |   |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 18 43   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>36<br>YRS.  |   | 7b. HOUR  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore CITY MD.                           |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, Baltimore, Maryland 21218 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Utility Man      |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  |   | 13b. CITY OR TOWN<br>Baltimore   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSHUA JONES   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH ELIMA JEFFERS   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>VN 212-46-6315  |  | 17. INFORMANT<br>ADDRESS<br>21218 VAMC medical records, Baltimore, Maryland   |  |  |   |   |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u><br>1541<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastatic Ca of Rectum</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST |  |  |  |   |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 22. I certify that (he) (this hospital) attended the deceased from <u>November 5</u> , 19 <u>79</u> , to <u>November 10</u> , 19 <u>79</u> , that (he) (we) lost<br>saw the deceased alive on <u>November 10</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.            |  |  |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><u>Michael H. Blume MD</u>   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>11/11/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Michael H. Blume MD</u>  |  |  |  |   | 22e. ADDRESS<br>VAMC, Baltimore, Maryland 21218  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |   |  |
| <u>Burial</u>  |  | <u>11-15-79</u>  |  | <u>Carver Cemetery</u>  |  | <u>Baltimore City, Md.</u>   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Donald Blume</u>  |  |  |  |   | 24b. ADDRESS<br><u>1348 Calhoun St</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 13 1979</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |   |  |                  |  |
|---|--|---|--|---|--|--|---|---|--|------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   | REG. NO.   |   |  |  |   |   |  |                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Hazel D. JONES</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 4, 1979</b>               |   |  | 2b. HOUR<br><b>11:57 AM</b>  |   |   |  |                  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 26, 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>                                       |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |   |   |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>analyst</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Govt</b>   |  |                  |  |
| 13a. STATE<br><b>Md</b>   |  |   | 13b. COUNTY<br><b>PG</b>   |   | 13c. CITY OR TOWN<br><b>Laurel</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>14307 Baltimore Avenue</b>   |                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leonard Lafayette Johnston</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Jane Steele</b>  |  |  |   |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>579 09 6402</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Erma Hensley same as above</b>                  |  |   |   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b><br><b>586-</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arterial insufficiency</b><br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Renal failure</b><br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |  |  |   |   |  |                  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>            |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |  |                  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 1, 1979</b> , to <b>November 4, 1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 4, 1979</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death. |  |   |  |   |  |  |   |   |  |                  |  |
| 22b. SIGNATURE<br><b>Krikor Tatoyan</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Krikor Tatoyan, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |  |   |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |   | 23b. DATE<br><b>Nov. 7, 1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cem</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Maryland</b>                        |   |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Donaldson Funeral Home, Laurel, Md</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Kristy M. Brady</b>                               |   |   |  |                  |  |



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |  |   |   |   |  |                                   |   |   |  |
|--|-------------------------|--|---|---|---|--|-----------------------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John E. Jones</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br><b>11 16 19 79</b> |   |   | 2b. HOUR<br><b>M</b>   |                                   |   |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 20, 1954</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>25</b> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.<br>HOURS MIN   | 2c. DATE PRONOUNCED DEAD<br><b>11 16 19 79</b>   |                                   |   | 2d. HOUR<br><b>11:20</b><br><b>M</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ky.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>   |                                   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Correctional Off. Corr. Inst.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |  | 13a. STATE<br><b>Md.</b>  |   |   | 13b. COUNTY<br><b>Baltimore</b>  |                                   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>  |                         |  | 13e. STREET ADDRESS<br><b>5341 Jamestown Court</b>  |   |   |  |                                   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William L. Jones</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pearl R. Trumpower</b>  |   |   |  |                                   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>218-62-7723</b>  |   | 17. INFORMANT ADDRESS<br><b>5341 Jamestown</b>  |  |                                   |   |   |  |
| 16c. (IF YES, GIVE WAR OR DATES)<br><b>Vietnam</b>   |                         |  | 17. INFORMANT ADDRESS<br><b>Mrs. Jolene Jones Court, Baltimore, Md.</b>   |   |   |  |                                   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Blunt trauma of chest with cardiac tamponade</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |   |   |   |  |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |  |   |   |   |  |                                   |   |   |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  |                                   |   | 20. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY<br>HOUR <b>XX</b> MONTH DAY YEAR<br><b>6:29 P.M. 11 16 1979</b>   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>driver in auto/auto impact</b> |                                   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Rt. 175 east of Tamar Dr. Columbia, Howard, MD</b>         |                                   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |   |  |                                   |   |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |                         |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>  |   |   |  |                                   |   | DATE SIGNED<br><b>11/17/79</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |                         |  | ADDRESS<br><b>111 Penn St. Balto., MD.</b>  |   |   |  |                                   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         |  | 23b. DATE<br><b>Nov. 20, 1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>                                       |  |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Quincy Franklin Penna.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>David Love</i>  |                         |  | ADDRESS<br><b>50 S. Broad St.,<br/>Waynesboro, Pa.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1979</b>  |                                   |   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Harry McCreedy</i>  |                         |  |   |   |   |  |                                   |   |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

March 20, 1972 25

x

U.S.A.

NY

Correspondence (L.A. Court, Ind.)

2311 Janssen Court

x

Baltimore

Baltimore

NY

Thompson  
2311 Janssen Court  
Baltimore, Md.

R.

Henry

Jones

L.

William

218-62-7723

Vietnam

Yes

Arrival Nov. 20, 1972 Date of Cemetery Quincy  
50 R. Road N.Y.  
Hartford, Ct.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph Jones</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>18</b> YEAR <b>79</b> |   | 2b. HOUR<br><b>11:40 P.M.</b>   |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>b</b>   | 5. DATE OF BIRTH<br>MONTH <b>01</b> DAY <b>01</b> YEAR <b>1908</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                 |   | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN <b>00</b>  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>city - Balto MD.</b>   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hosp</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK, FOR MOST OF WORKING LIFE)<br><b>-</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                     |   |   |
| 13a. STATE<br><b>MD</b>   |   | 13b. COUNTY<br><b>Balto</b>   | 13c. CITY OR TOWN<br><b>Balto</b>                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>816 Carey St</b>  |
| 14. FATHER'S NAME<br>FIRST <b>N/A</b> MIDDLE <b>-</b> LAST <b>-</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>N/A</b> MIDDLE <b>-</b> LAST <b>-</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>unk</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>219 034133</b>   |   | 17. INFORMANT<br><b>Margaret Jones</b> ADDRESS<br><b>816 N. Carey St. 21217</b>                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-resp arrest</b><br><b>585-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-</b>  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>-</b>   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/18 19 79</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/18</b> 19 <b>79</b> to <b>11/18</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/18</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Howard Boltansky</b> DEGREE <b>MD</b>  |   |   |   | 22c. DATE SIGNED<br><b>11/19/79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HOWARD BOLTANSKY</b>  |   |   |   | 22e. ADDRESS<br><b>Univ Hosp S. Greene St</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11/24/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                                      |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1979</b>   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>VERNON R. BAILEY</b>   |   | ADDRESS<br><b>-1348 N. CALHOUN ST. 21217</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Harvey Bailey</b>  |   |

MEDICAL CERTIFICATION

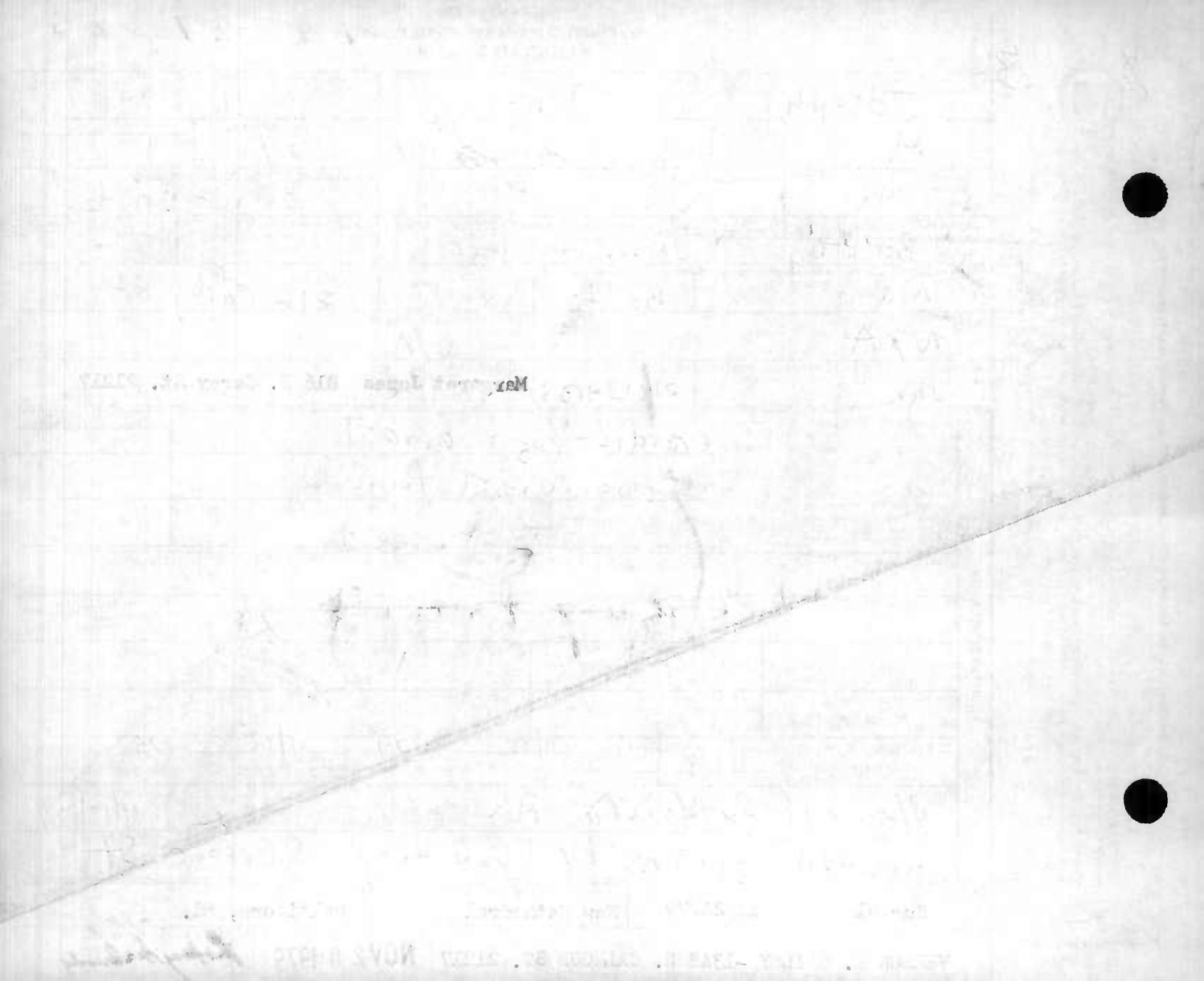
29

1

3



1602 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |  |   |                             | REG. NO. 27526  |  |
|--|--|-------------------------|--|--|--|---|--|---|-----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Joseph Bernard Jones, Jr.</b>  |  |                         |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 27 1979</b>                               |  |   | 2b. HOUR<br><b>4:15 A M</b> |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 10 1938</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>41 YRS.</b>   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |                             | 2c. DATE PRONOUNCED DEAD<br><b>11 27 1979</b>                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                             | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Md</b>  |  |                         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                             | 13e. STREET ADDRESS<br><b>1519 S. Hanover Street</b>                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Bernard Jones Sr.</b>  |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Mae Williams</b>  |  |   |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>216 34 5765</b>   |  | 17. INFORMANT ADDRESS<br><b>Joseph B. Jones Sr. 1519 S. Hanover St.</b>   |  |   |                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Gunshot Wounds (handgun)</b><br>9650<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |  |  |  |   |  |   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                         |  |  |  |   |  |   |                             |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                             | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1:05 PM 11-25-1979</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot by unknown assailant (s)</b> |  |   |                             |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>vacant house</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1902 W. Franklin St., Baltimore City, Md.</b>                         |  |   |                             |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |                             |   |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |  | DATE SIGNED<br><b>11/27/79</b>  |                             |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn St.</b>   |  |   |  |   |                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>11-30-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |                             |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Isaiah L. Brown &amp; Son P. A. 1913 W. Balto. St</b>   |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                             |   |  |

1.10.1941

1.10.1941

(10.10.1941)

1.10.1941

1.10.1941

1.10.1941

1.10.1941

1.10.1941

1.10.1941

1.10.1941



Items #1a-22a Film G538 12/3/79 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
|---|---------|--|--|---|--|---|--|---|--|--------------------------|--|--|--|-----|--|-------|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | KNOWN ESTIMATED          |  | MONTH  |  | DAY |  | YEAR  |  | 2b. HOUR            |  |
| Joseph D. Jones   |         |  |  |   |  |   |  | 11 6 19 79  |  |                          |  | 11   |  | 6   |  | 19 79 |  | 11:15 A M           |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD |  | MONTH  |  | DAY |  | YEAR  |  | 2d. HOUR            |  |
| Male  | Black   | 11 1 1927  |  | 52 YRS.   |  |   |  |   |  | 11 6 19 79               |  | 11   |  | 6   |  | 19 79 |  | 11:15 A M           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED   |  | WIDOWED   |  | DIVORCED                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                               |  |     |  |       |  |                     |  |
| North Carolina  |         | U. S. A.   |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  | Baltimore City, MD. |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| Baltimore   |         | 3808 Old Frederick Road                                  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                          |  |  |  |     |  |       |  |                     |  |
| Maryland  |         |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3808 Old Frederick Road   |  |                          |  |  |  |     |  |       |  |                     |  |
| 14. FATHER'S NAME   |         |  |  | 15. MOTHER'S MAIDEN NAME                                      |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| Will Jones  |         |  |  | Connie Hicks  |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         |  |  | 16b. SOCIAL SECURITY NO.                                      |  |   |  | 17. INFORMANT   |  |                          |  | ADDRESS  |  |     |  |       |  |                     |  |
| Yes   |         |  |  | 240-34-0768   |  |   |  | Della Pegram  |  |                          |  | 3808 Old Frederick Road  |  |     |  |       |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u>   |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.   |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| (c)   |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
|   |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| 20. AUTOPSY?  |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                          |  |  |  |     |  |       |  |                     |  |
|   |         |  |  | HOUR A.M. MONTH DAY YEAR                                      |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
|   |         |  |  | P.M. 19   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION   |  |                          |  |  |  |     |  |       |  |                     |  |
|   |         |  |  |   |  |   |  | STREET CITY OR TOWN COUNTY STATE  |  |                          |  |  |  |     |  |       |  |                     |  |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u>   |         |  |  | TITLE (SPECIFY) <u>Assistant</u>                              |  |   |  | MEDICAL EXAMINER  |  |                          |  | DATE SIGNED <u>11/6/79</u>   |  |     |  |       |  |                     |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Virginia L. Dolan, M.D.</u>  |         |  |  | ADDRESS <u>111 Penn Street</u>                                |  |   |  |   |  |                          |  |  |  |     |  |       |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |         |  |  | 23b. DATE <u>11/12/1979</u>                                   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>                  |  |                          |  | 23d. LOCATION CITY OR TOWN <u>Baltimore, Maryland</u> COUNTY STATE |  |     |  |       |  |                     |  |
| 24. FUNERAL DIRECTOR NAME <u>Wm. C. March / F/H</u>   |         |  |  | ADDRESS <u>1101 East North Avenue</u>                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR <u>NOV 9 1979</u>                               |  |                          |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                      |  |     |  |       |  |                     |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
 (VR A15 ME (5))  
 30M 7/73

June 4, 1964

TO: Mr. Tolson

FROM: Mr. DeLoach

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

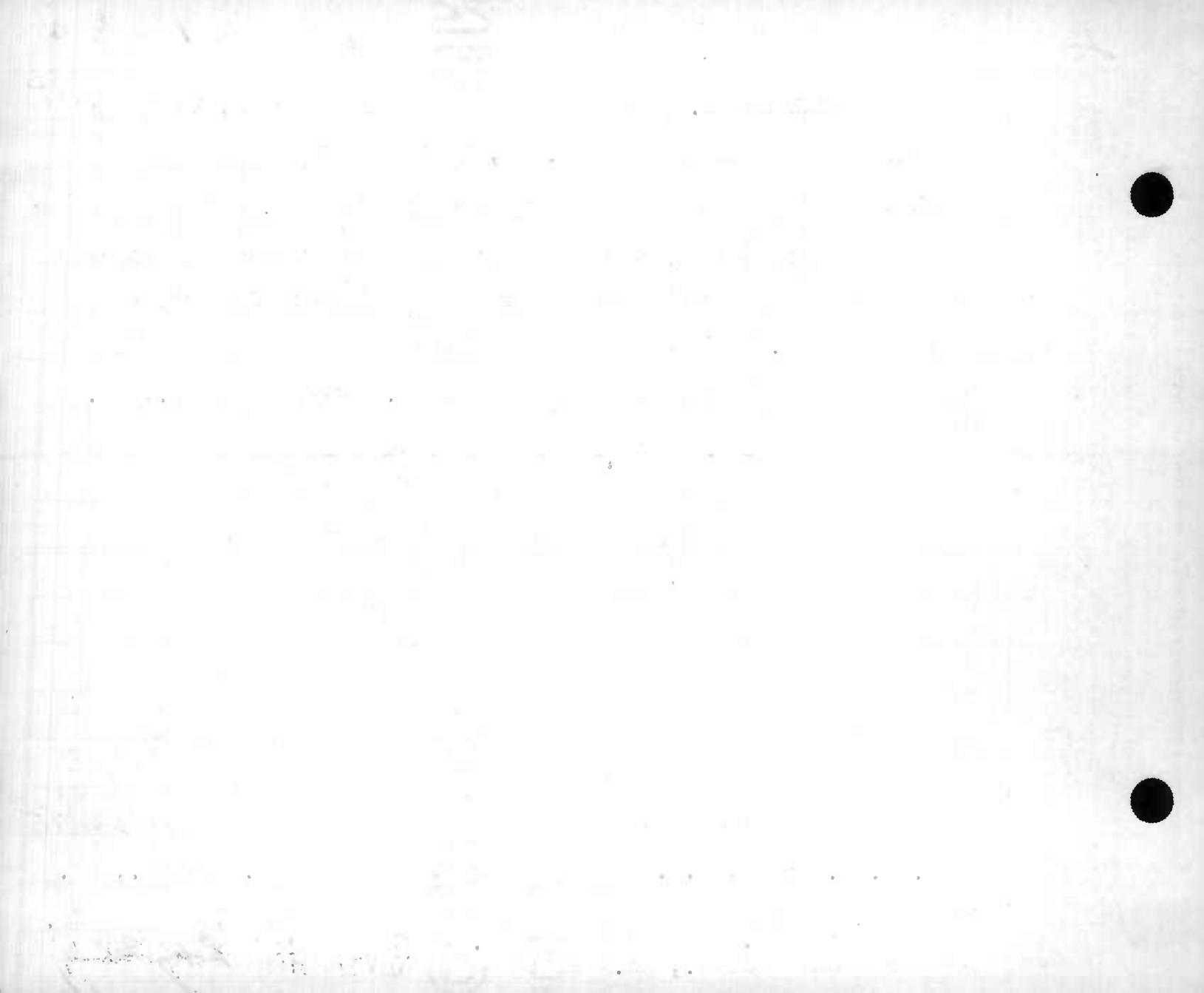
15. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 79 27528  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR   |  |
| Lillian A. JONES  |  |  |  |  |  |  |  | November 24, 1979   |  | 800 P.M.   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN.                           |  |
| Female  |  | White  |  | Nov. 20, 1892  |  | 87 YRS.  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Maryland  |  | USA  |  |  |  | Baltimore City MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore   |  | Hamilton Nursing Center  |  |  |  | Homemaker  |  | Own Home  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |  |  |   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland  |  |  |  | Baltimore  |  |  |  | 3024 Abell Avenue   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |
| Charles W. Harvey   |  |  |  | Mary Conley  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |
| No  |  |  |  | 217 14 2551  |  | William S. Arnold Balto., Md.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CVH</u>   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> |  |
| 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus, ASCVD</u>  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatoid arthritis</u>  |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN   |  | COUNTY  |  | STATE  |  |
|   |  |  |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>75</u> , to <u>Nov.</u> , 19 <u>79</u> , that (I) <u>was</u> last saw the deceased alive on <u>10/20/79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>not</u> (I) did not view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |  |  |  |  | 22c. DATE SIGNED  |  |  |  |
| <u>Dr. I. W. Fromm, M.D.</u>  |  |  |  |  |  |  |  | <u>11/26/79</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |  |
| Dr. I. W. Fromm, M.D.   |  | 8014 Old Harford Rd. Balto., Md.   |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN   |  | COUNTY  |  | STATE  |  |
| Cremation   |  | 11/26/79   |  | Greenmount   |  | Baltimore,   |  |   |  | Md.  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212  |  |  |  |  |  | NOV 26 1979  |  | <u>Henry W. Jenkins</u>   |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 7 9 2 7 5 2 9   |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                      |  |
| Herman   |  | H  |  | Kabernagel   |  |   |  | November 11, 1979   |  | 11:40P M                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                   |  |
| male   |  | white  |  | 10 24 15   |  | 64 YRS  |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |   |  |
| Maryland   |  | USA  |  |  |  | Baltimore City MD   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY             |  |
| Baltimore  |  | Church Home Hospital   |  |  |  |   |  | Metal worker  |  | Martin Co                                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS                           |  |
| Md   |  |  |  | Baltimore  |  |   |  |   |  | 6607 Marne Avenue. 21224                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |   |  |   |  |
| Herman H Kabernagel  |  |  |  | Sara E   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |   |  |
| no   |  | 213 05 4075  |  | Mrs. Madeline Kabernagel 6607 Marne Ave  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of the Pancreas</u><br>1579<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)  |  |  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 5</u> 19 <u>79</u> , to <u>Nov 11</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov 11</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>A.F. Nowr MD</u>   |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>11/12/79</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A. F. NOWR</u>  |  |  |  | 22e. ADDRESS <u>100 N. Broadway, Baltimore, Md 21231</u>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>11/14/79</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>   |  | 23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u></u> STATE <u>Md</u>  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <u>Walter Dabrowski</u>  |  |  |  | ADDRESS <u>1005 Dundalk Avenue</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <u>NOV 15 1979</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |  |



November 11, 1979

White  
Wife  
10 24 1  
X  
Baltimore City

Baltimore  
Church Home Hospital  
Social Worker  
Baltimore  
X  
607 White Avenue, 1114

Green  
H  
Kaderbush  
Sara  
11 01 4075 Mrs. Madeline Kaderbush 607 White Ave

Historic Catonsville of the Patrons

Nov 11, 79  
Nov 11, 79  
Nov 11, 79

11/11/79

A F Now  
A F Now

100 N. Broadway, Baltimore, MD 21201

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100 N. Broadway, Baltimore, MD 21201

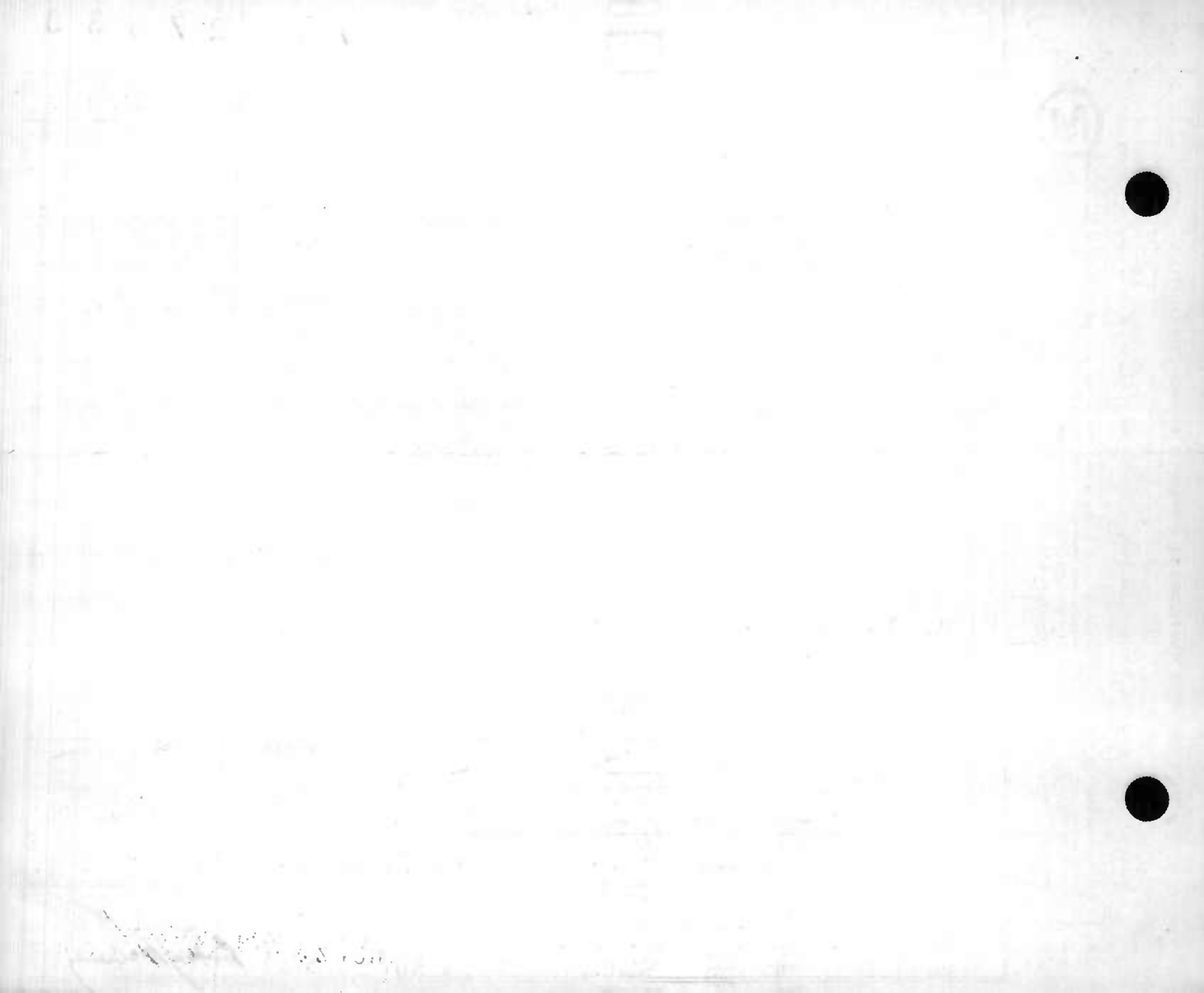
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 2 7 5 3 0   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  | 2b. HOUR P. M.                               |  |
| BARNEY   |  |   |  |   |  | KAHN  |  | NOVEMBER 16, 1979  |  | 5:05   |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| MALE   |  | WHITE   |  | JULY 29, 1899   |  | 80 YRS  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| MARYLAND   |  | USA   |  |   |  | BALTIMORE CITY MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| BALTIMORE  |  | MT. SINAI NURSING HOME  |  |   |  |   |  | MERCHANT   |  | RETAIL                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |  |  |
| 13a. STATE   |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS   |  |  |  |  |  |
| MARYLAND   |  | BALTO.  |  | REISTERSTOWN  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 6 TAYLOR CIRCLE # 21138  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |  |  |
| LOUIS  |  |   |  | ANNA  |  |   |  | MARKS  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |
| NO   |  |   |  | 577-05-7158   |  | Mrs. ARLEEN KAHN 1678 1 <sup>ST</sup> AVE N.Y. N.Y. 10028           |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pancreatic Cancer</u><br>1579<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF       |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
| 10-26-79   |  | CHOLELITHIASIS  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |
|  |  |   |  |   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
|  |  |   |  |   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>16 NOV</u> , 19 <u>79</u> , that (I) <u>me</u> last saw the deceased alive on <u>16 NOV</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>me</u> <u>did not</u> view the body after death. |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE  |  |   |  |   |  | 22c. DATE SIGNED   |  |  |  |
| <u>Arthur M. Vernon</u>  |  |   |  |   |  |   |  | 10 NOV 79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |   |  |  |  |  |  |
| ARTHUR M. VERNON MD  |  | 3640 FORDS LANE BALTO MD 21215  |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |  |  |
| BURIAL   |  | NOV. 19, 1979   |  | RODGE ZEDEK   |  | BALTO. MD.  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                       |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  |   |  | NOV 23 1979   |  | <u>Arthur M. Vernon</u>  |  |  |  |

BP \_\_\_\_\_





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>HELEN KAPLAN</i>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 6 79</i>  |   | 2b. HOUR<br><i>2:40</i> M  |  |  |
| 3. SEX<br><i>FEMALE</i>  |  | 4. RACE<br><i>WHITE</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 5 XXX</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>85 XXX</i> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>LATVIA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Sinai Hospital of Balto</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br><i>MD.</i>   |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>4377 Crosthights Rd 21205</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>UNKNOWN UDELEWITZ</i>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>UNKNOWN</i>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><i>NO</i>  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><i>218-12-4872</i>   |   | 17. INFORMANT ADDRESS<br><i>IRVIN KAPLAN 6607 WICKFIELD RD. #21208</i> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/6</i> , 19 <i>79</i> , to <i>11/6</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/6</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>F.B. Neasman, MD</i>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><i>11/6/79</i>                                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>F.B. Neasman</i>   |  |   |  |   | 22e. ADDRESS<br><i>Sinai Hosp. of Balto.</i>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>11-8-79</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>BNAI ISRAEL CONG.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTIMORE MD</i>                               |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>SOL LEVINSON &amp; BROS., INC.</i><br>6010 REISTERSTOWN RD., BALTO., MD 21215  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 14 1979</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Ruby K. Brady</i>   |  |

MEDICAL CERTIFICATION

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UNITED STATES DEPARTMENT OF THE INTERIOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 2 7 5 3 2   |  |   |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Mary A. Jones</i>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>November 22, 1979</i>   |  |  |  | 2b. HOUR<br><i>6:46P M</i>   |  |
| 3 SEX<br><i>F</i>  |  | 4 RACE<br><i>B</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9 3 15</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>64</i> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Maryland General Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>Md.</i>   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><i>Balto.</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Oscar Hudson</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Maebel Harrison</i>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><i>220-09-9988</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>William Hudson 3042 Grantley Ave.</i>                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br><i>1629</i><br>IMMEDIATE CAUSE (a) <i>Congestive Heart Failure due to</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Pericardial Involvement Of</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <i>Bronchogenic Cancer</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>2 months</i>  |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>Renal Failure</i>   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>November 3, 1979</i> to <i>November 22, 1979</i> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <i>November 22, 1979</i> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Jing Liu, M.D.</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><i>11/22/79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Jing Liu, M.D.</i>   |  |   |  | 22e. ADDRESS<br><i>c/o Maryland General Hospital</i>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11/27/79</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn Cem.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto., Md.</i>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Wm C March F/H 1101 E. North Ave.</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 27 1979</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Priscilla K. Brady</i>                              |  |  |  |

11/22/79 11/22/79 11/22/79 11/22/79 11/22/79

Baltimore City

Marvin General Hospital

Baltimore

Consecutive Heart Failure due to

Pericardial Involvement of

Bronchogenic Cancer 3 months

Renal Failure

November 22 79 X November 22 79 X November 22 79 X November 22 79 X

11/22/79

Marvin General Hospital

and City W.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED ON APPROVAL BY DR. SMITH

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 7 9 2 7 5 3 3   |  |
|--|--|--|--|---|--|
| 1- STATE REGISTRAR   |  |  |  | REG. NO.  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>George JORDAN (Jordan)  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>November 22, 1979   |   | 2b HOUR<br>10:55pm   |
| 3 SEX<br>Male  | 4 RACE<br>Negro  | 5 DATE OF BIRTH MONTH DAY YEAR<br>7 30 1898  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   | 7b CITIZEN OF WHAT COUNTRY?<br>U. S. A.  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE Maryland 13b COUNTY 13c. CITY OR TOWN Baltimore   |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br>804 McDonogh Street                      |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Austin Jordan  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sally  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO.<br>216-10-1321   |  | 17 INFORMANT ADDRESS<br>Mary Jordan 804 McDonogh Street   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cervical Spinal Cord Injury</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cervical Spondylosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u><br><u>7 days</u><br><u>Years</u> |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebrovascular Accident</u>   |  |  |  |   |  |
| 19a DATE OF OPERATION<br><u>none</u>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>2 P.M. 11 15 1979</u>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>Pt fell down stairs</u> |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>Home</u>  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE<br><u>201 N. Broadway Baltimore Md.</u>                       |  |
| 22a I certify that (I (this hospital) attended the deceased from <u>11/15 1979</u> to <u>11/22 1979</u> , that (I (we)) last saw the deceased alive on <u>11/22 1979</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b SIGNATURE<br><u>Barry Mayrmon</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br><u>11/22/79</u>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Barry Mayrmon</u>   |  | 22e ADDRESS<br><u>Johns Hopkins Hospital Baltimore</u>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>11/28/1979   |  | 23c NAME OF CEMETERY OR CREMATORY<br>King Memorial Park   |  |
| 24 FUNERAL DIRECTOR NAME<br>Wm. C. March F/H   |  | ADDRESS<br>1101 East North Avenue  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Co., Maryland   |  |
| 25a DATE REC'D. BY REGISTRAR<br>NOV 28 1979  |  | 25b REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |

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